# APPLICATION FOR CERTIFICATE OF PUBLIC ADVANTAGE

SUBMITTED BY:

Hendrick Health System

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PUBLIC REDACTED VERSION

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Hendrick Health System ("Hendrick"), a Texas non-profit corporation, respectfully submits this application for a Certificate of Public Advantage pursuant to Texas Health and Safety Code, Section 314A.052. The application seeks a certificate governing the transaction contemplated by an Asset Purchase Agreement to acquire, among other things, substantially all of the assets used in the operation of Abilene Regional Medical Center ("Abilene Regional"), an acute care hospital located in Taylor County, Texas.

Small towns, cities and rural communities throughout the United States are losing access to high-quality health care as local hospitals struggle to contain costs while providing essential care. The crisis is particularly acute in Texas, which has witnessed more rural hospital closures than any other state. Twenty hospitals in Texas have closed since 2010. The Texas Legislature recently enacted Chapter 314A ("the Law") to address this crisis by facilitating certain rural hospital transactions and imposing ongoing state supervision to ensure that the transactions benefit the local communities. The transaction contemplated here is exactly what the Texas Legislature intended. It would increase services available to rural communities in Texas by creating substantial cost savings and other efficiencies; fostering the creation of jobs in our local communities; and, most importantly, improving health care access and outcomes for rural populations disproportionately composed of poor and elderly citizens. On the other side of the balance, there is no appreciable danger of any meaningful competitive harm from the transaction. Therefore, the Commission should grant the application and issue a Certificate of Public Advantage.

## I. THE MERGER AGREEMENT

### A. The Parties

Since 1924, Hendrick Health System has operated as a premier health care provider in the Abilene region, serving patients in Taylor County and 23 neighboring counties, through Hendrick and other related health care facilities. Hendrick was the first hospital to serve Midwest Texas and today is a thriving 540-licensed bed acute care hospital. Hendrick offers the only Level III trauma center within 100 miles of Abilene, as well as a women's center, rehabilitation hospital, cancer center, hospice center, Level III Neonatal Intensive Care Unit ("NICU"), and centers of excellence in radiology and cardiovascular rehabilitation, among other innovative services. Hendrick has been recognized and awarded for delivering high-quality health care, access to critical specialties, and excellence in patient engagement. Hendrick provides aggressive, innovative treatments and preventative health care measures ranging from services such as cancer screenings and prenatal education courses to electrophysiology procedures and pediatric intensive care.

The Hendrick family, for whom the institution was named, bestowed a major financial gift to pay off the hospital's debts and expand a new wing. This launched Hendrick's not-for-profit mission and commitment to community care. Hendrick was the first medical provider in the area to offer specialized services, creating departments to fill the needs of its community. Today, as one of the seven health care institutions affiliated with the Baptist General Convention of Texas and with more than 3,500 employees, Hendrick continues to deliver high-quality health care emphasizing its ministry mission—the "excellence and compassion consistent with the healing ministry of Jesus Christ."[1]

Abilene Regional is a 231-bed, community health care provider affiliated with Community Health Systems ("CHS"), a Tennessee for-profit corporation.[2] The hospital was built by a group of local physicians and investors on East Highway 80 and opened as West Texas Medical Center in 1968. Abilene Regional resides on a 33-acre complex in south Abilene, Texas. Its mix of services is commensurate with a community hospital of like size, including an emergency department, an Accredited Chest Pain Center with PCI, an Accredited Stroke Center, orthopedic center, cardiac rehab, robotic assisted surgery, and a Level II NICU.

B. Description Of The Transaction

On August 28, 2019, the parties signed a letter of intent to enter a transaction in which Hendrick would acquire, among other things, the assets used to operate Abilene Regional and other nearby facilities. (A copy of the definitive agreement is submitted with this application as Appendix E.) With its focus on providing high-quality health care, local community leadership, and commitment to pastoral care, Hendrick believed that the transaction would benefit the community. Hendrick's leadership and community-led Board of Directors evaluated such a potential transaction carefully, taking into consideration the need for providing more patient access to local and non-profit health care and Hendrick's full or near-full capacity at many of its acute care service providers. Hendrick determined that the transaction would advance its mission to preserve and expand access to quality, community-based, not-for-profit health care in Midwest Texas, while avoiding a costly process of constructing new facilities to make room for more patients. The transaction would combine the high-quality, award-winning services of Hendrick's hospital, clinics, and outpatient centers with those of Abilene Regional and facilitate substantial cost savings. Because of Hendrick's non-profit status, those cost savings would be re-invested in the community. Moreover, the transaction would meet the community's immediate and long-term health needs—ensuring that patients would have better access to the health care they need, when and where they need it.

The proposed transaction comes at a time of sweeping changes in health care delivery. Communities in Texas and across the nation are seeing community hospitals close as they struggle to navigate historic financial, regulatory, and operational challenges. This transaction would ensure that current and future generations of patients in Midwest Texas would continue to have access to high-quality, affordable care, provided and led by community members. The proposed transaction would generate cost savings that would help Hendrick develop additional low-cost, high-quality services, and protect access to a full complement of health care services in the Abilene community and greater Midwest Texas.

C. The Hospitals

1. Facilities, Service Lines And Specialties

Hendrick provides an extensive portfolio of specialized services, including:

- Cardiology / Cardiovascular & Thoracic Surgery. Hendrick provides comprehensive care including a non-invasive cardiovascular lab, cardiac cath lab, cardiac electrophysiology lab, peripheral arterial disease clinic, certified cardiac

rehab program, hybrid cardiovascular surgery suite, cardiac interventional care unit, and heart failure program.

- Critical Care. Hendrick has a 24-bed unit with an intensivist program.

- Emergency. Hendrick's main campus has a 34-room emergency department. As the only Level III trauma center within 100 miles of Abilene, Hendrick has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations. In South Abilene, Hendrick has a freestanding emergency department.

- Endocrinology. Hendrick provides care to patients with diabetes, endocrine and metabolic disorders on an inpatient and outpatient basis. This department is supported by education and workshops provided by Hendrick Diabetes Center in Abilene and Brownwood.

- Gastroenterology. Hendrick provides GI care on an inpatient basis in Abilene and an outpatient basis in Abilene and Brownwood. Hendrick has a GI hospitalist program in place as well.

- Labor & Delivery. Hendrick has four triage rooms, four antenatal suites, eight labor and delivery suites, and three ORs. The hospital offers continuous fetal monitoring, non-stress testing, a Level II nursery, and lactation consultant services. Many of these services are provided through a successful OB-hospitalist program.

- Neonataology/NICU. Hendrick offers a 25-bed, Level III NICU designed to care for babies at 23 weeks gestation and up. Care is provided by on-site, board-certified neonatologists, alongside specially trained nurses, respiratory therapists, PTs, OTs, SLPs, pharmacists, and other care givers.

- Neurology. Hendrick provides a full spectrum of neurology care for disorders involving the central/peripheral/autonomic nervous systems. All imaging modalities are available, including angiograms (MT/CT, Catheter). Hendrick is designated as an Advanced Primary Stroke Center and is equipped with a neuro-interventional suite.

- Neurosurgery. Hendrick's neurosurgery department provides surgical intervention of disorders involving the central/peripheral/autonomic nervous systems. Services also include aneurysm and endovascular treatment as well as stereotactic radiosurgery.

- Oncology/Hematology. Hendrick provides these services on an inpatient and outpatient basis. The treatments include chemotherapy, radiation therapy, and surgical intervention. In addition, Hendrick has a 28-bed oncology unit with specially trained nurses and pharmacists.

- Orthopedics. Hendrick employs orthopedists providing surgical and non-surgical care for disorders of the musculoskeletal system affecting patients of all ages. These specialists also perform total joint replacements for all major joints and offer surgeries on an inpatient and outpatient basis in a specialized 20-bed orthopedic unit for inpatients. Hendrick also has a joint venture education class offered to patients prior to total hip and total knee replacement.

- Pediatrics. Hendrick is the only Midwest Texas hospital designated as a Children's Miracle Network Hospital. It operates a 20-bed inpatient pediatric unit, a dedicated pediatric intensive care unit ("PICU"), and a Child Life Specialist Program. Care is provided by pediatricians and specially trained nurses and therapists. Pediatricians on the Hendrick Medical Staff also treat patients on an outpatient basis.

- Pulmonary. Hendrick offers care involving disorders of the respiratory system. Hendrick has an onsite pulmonary rehabilitation program that is nationally certified by the American Association of Cardiovascular and Pulmonary Rehabilitation.

- Radiology. Hendrick offers inpatient, outpatient, and emergency imaging utilizing all modalities, including: 3D mammography, MRI, CT, ultrasound, diagnostic x-ray and fluoroscopy. Interventional radiology, nuclear medicine, radiation therapy, cardiac imaging, nuclear stress tests and chemical stress test services are also available.

- Urology. Hendrick offers surgical and non-surgical care for anatomic or structural disorders of the urinary tract as well as disorders of the male reproductive system.

- With a Da Vinci surgery robot, Hendrick offers high-quality, minimally invasive surgeries, and follow-up care provided by board-certified general surgeons.

As a smaller hospital, Abilene Regional provides fewer specialized services than does Hendrick, is capable of providing care for less serious traumatic injuries, and has procedures in place to stabilize and quickly transfer patients requiring a more advanced scope of care to a higher acuity level facility such as Hendrick.

Hendrick directly employs 101 physicians and contracts with over 80 additional physicians, most of whom specialize in complex medical procedures such as oncology, nephrology, neurosurgery, plastic/reconstructive surgery, and cardiothoracic and vascular surgery. Abilene Regional employs 30 physicians.

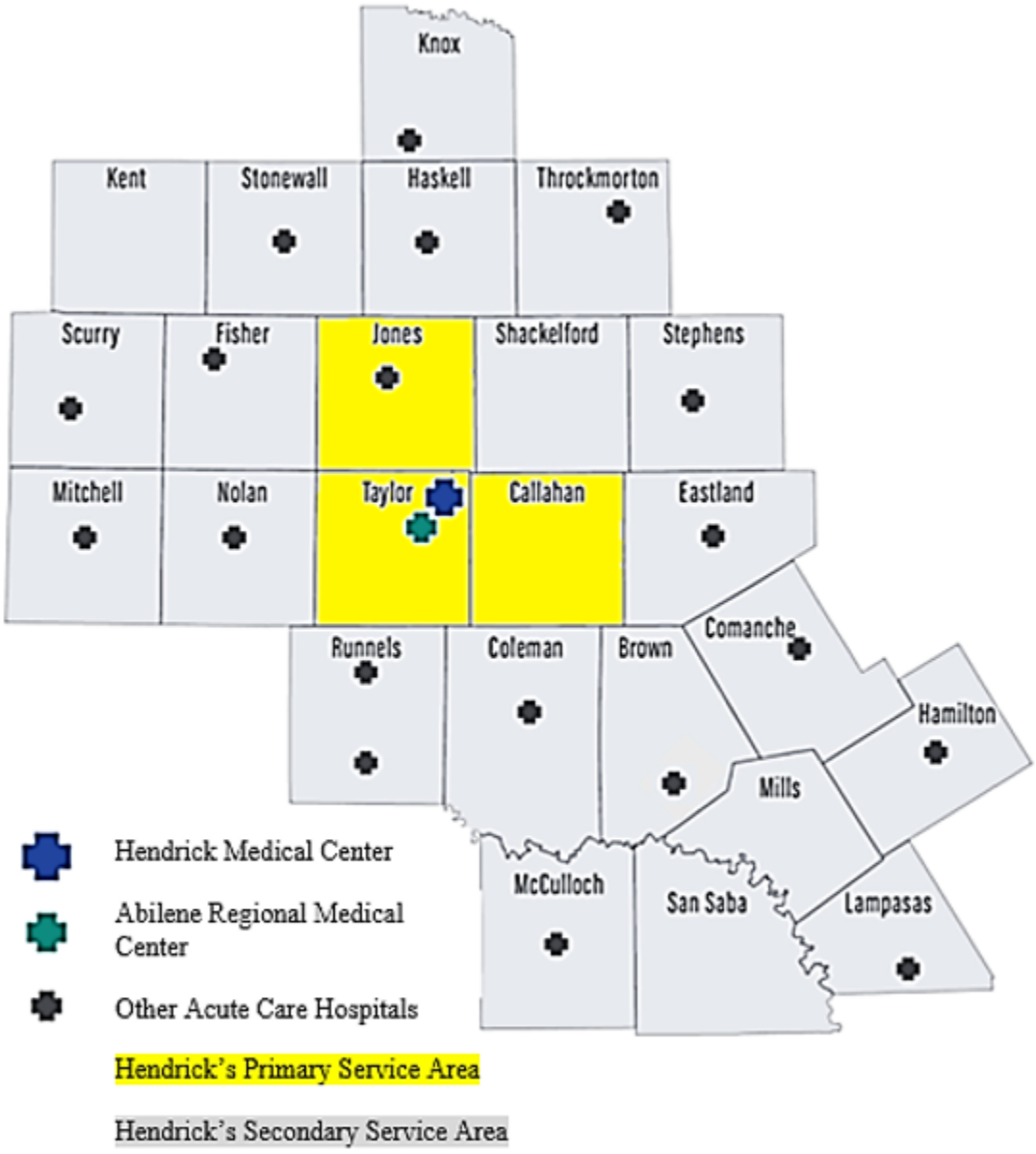
2. Geographic Service Areas

Hendrick and Abilene Regional serve largely different geographical areas and care for largely distinct populations. While there is some degree of overlap—Hendrick and Abilene Regional both serve patients in Taylor County—Figure 1 below demonstrates that Hendrick's

primary service area covers three counties across Midwest Texas (Callahan, Jones, and Taylor Counties). In addition, in its secondary service area, Hendrick draws patients from Haskell, Throckmorton, Scurry, Fisher, Shackelford, Stephens, Mitchell, Nolan, Eastland, Runnels, Coleman, Brown, Comanche, Hamilton, Mills, McCulloch, San Saba, Lampasas, Knox, Kent, and Stonewall Counties. The 24 counties in which Hendrick draws patients have a population of almost 400,000 residents.

Abilene Regional's primary service area is limited to Taylor County, as demonstrated in Figure 2.

**Figure 1: Hendrick's 24-County Service Area & Other Inpatient Hospitals**




*The primary service area includes counties from which 75% of Hendrick's patients are drawn. The secondary service area includes counties from which 90% of Hendrick's patients are drawn.

**Figure 2: Abilene Regional Hospitals & Outpatient Centers**


| ***Legend for Figure 2*** | |
|---|---|
| | Abilene Regional's locations (including Abilene Regional Medical Center; a care transition clinic; an orthopedic institute; South Abilene Surgical Associates; and 13 outpatient locations) |

3. Volumes And Operating Statistics

As demonstrated in Exhibit A, Hendrick has significantly higher volumes than Abilene Regional. [redacted] The hospitals are not of like-kind.

[redacted]

Hendrick's volumes have grown over the last five years, and continue to grow each year. [redacted]

Despite best efforts to accommodate all patients in need, Hendrick is capacity constrained. Importantly, even when Hendrick's occupancy rate is documented at less than 100%, it may still be at capacity because hospital beds are not all "interchangeable"—i.e., certain patients must be placed in specific units or wings. For example, intensive care unit ("ICU") patients require unique services, equipment, facilities, and staffing not available elsewhere in the hospital. In addition, Hendrick's capacity figures understate its constraints as Hendrick does not report capacity utilization for patients who are in observation status or being held in the emergency department waiting for an inpatient bed.

[redacted]

[redacted]

Patients will be better served, and each hospital should realize operating efficiencies. Overall, the transaction will benefit the public by maintaining and improving the quality, efficiency and accessibility of health care in the combined service area.

## II. AUTHORIZATION TO PURSUE APPLICATION

In response to the health care crisis facing Texas communities (discussed below in Section IV), the Texas Legislature explored solutions during its 2019 session to maintain the availability of quality health care in rural areas. The Legislature concluded that rural hospitals "would benefit from having additional tools to combat challenges and improve health care services."[3] The Legislature and Governor Abbott provided rural hospitals with those tools by enacting House Bill 3301 (the "Law"), which authorizes certain merging hospitals[4] to apply for Certificates of Public Advantage ("COPAs").

Merging hospitals that wish to obtain a COPA must submit an application to a designated State agency, chosen by the Governor of Texas, after which the agency reviews the application and issues a decision within 120 days of the filing. The Governor selected the Texas Health and Human Services Commission (the "HHSC" or the "Commission") to serve as the designated agency for this application.

If, under the totality of the circumstances, the HHSC finds that the likely benefits of the transaction outweigh any disadvantages associated with a reduction in competition, the Law directs that the COPA shall issue. In making its determination, the Commission must consider the effect of the transaction under certain enumerated factors (the "Criteria for Approval"). The HHSC also may consider whether to include terms or conditions of compliance in connection with the certificate, if necessary.

Further, the Law provides that the Attorney General of Texas shall review the COPA application and advise the designated agency about his or her views on the transaction's effects with regard to quality, efficiency, and accessibility of health care services offered to the public.

To that end, the Law establishes a program whereby after approval, the State will actively supervise the ongoing conduct of the combined entity to ensure that it continues to benefit the public.[5] The Law also states the Legislature's conclusion that the best way to maintain access to quality healthcare in rural Texas is to supplant state and federal antitrust laws with a process for regulatory approval, oversight, and active supervision under the COPA process.

## III. CRITERIA FOR APPROVAL

The Law articulates several goals that the transaction should foster, including that the transaction likely benefits the public by maintain or improving the:

- quality of health care services offered to the public;
- efficiency of health care services offered to the public; and
- accessibility of health care services offered to the public.

While those goals serve as considerations to the parties in entering a covered transaction, the Law provides a simple standard for the Commission in reviewing a COPA application. The HHSC must simply determine under the totality of circumstances whether "the proposed merger would likely benefit the public by maintaining or improving the quality, efficiency, and

accessibility of health care services offered to the public," and whether those likely benefits "outweigh any disadvantages attributable to a reduction in competition" that may stem from the transaction. To facilitate this evaluation, the Law provides for COPA applications to provide information about:

- how the proposed merger would likely benefit the public; and
- how the likely benefits resulting from the proposed merger may outweigh any anticompetitive effects of joining together competitors to address unique challenges in providing health care services in rural areas.

The Law calls for the agency to "consider" the effect of the merger on the following factors, but emphasizes that this is a non-exhaustive list:

- quality and price of hospitals and health care services provided to Texas citizens;
- preservation of sufficient hospitals within a geographic area to ensure public access to acute care;
- cost efficiency of services, resources, and equipment provided or used by the hospitals;
- ability of health care payors to negotiate payment and service arrangements with hospitals; and
- extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons providing goods and services to, or in competition with, the merging hospitals.

## IV. COMPETITIVE EFFECTS: THE RURAL HEALTH CARE CRISIS IN TEXAS

Rural hospitals in America are facing significant financial challenges—with more than 600 rural health care facilities, including 300 hospitals, currently estimated to be vulnerable to closure.[6] In Texas, this crisis is especially acute, where the State has seen an epidemic of rural hospital closures.[7] Since 2010, 20 rural Texas hospitals have closed—more than in any other State.[8] Moreover, experts believe that rural hospital closures in Texas could nearly double in the near-term, with 13 additional Texas hospitals at risk of closing.[9] Texas had 300 rural hospitals in the 1960s, when the state population as just over 10 million. That number is down to just 158 rural hospitals in 2019,[10] while the state population has increased to over 28 million.[11] These hospitals, which are often the only health care service providers for many miles, tend to serve older and poorer patients, and accordingly face higher burdens of unpaid or underfunded care, such as Medicare and Medicaid.[12]

The closure of rural hospitals in Texas has affected almost every part of the State. Today, 63 Texas counties—roughly a quarter of the State—have no hospitals.[13] The remaining 155 rural hospitals in Texas provide care to more than 3.1 million Texans, serving 12% of the Texas population and covering emergency and local hospital care for 85% of the state's geography.[14]

Many rural hospitals face unfavorable patient reimbursement trends, substantial capital needs relating to their physical plant and ongoing clinical operations, unfavorable patient reimbursement trends, and difficulty recruiting health care providers to serve their patients.

This crisis acutely affects Midwest Texas, which is generally coextensive with Hendrick's 24-county service area. In Midwest Texas, almost 400,000 people, or 1.3% of the state's population, live across 22,305 square miles.[15] Of the 24 counties in Midwest Texas, 19 are classified as rural and 10 are sparsely populated, with fewer than seven people per square mile.[16] Abilene is the only metropolitan area in Midwest Texas and serves as a health care hub for people living within the region.

A. Factors Contributing To Rural Hospital Financial Decline

***Payor mix***. Rural hospitals tend to treat older and less affluent patients, and therefore shoulder a higher burden of unpaid or underfunded care, including Medicare and Medicaid patients, relative to urban hospitals.[17] Medicare and Medicaid reimbursement rates are typically below the actual cost of providing care to program beneficiaries. A recent survey of hospitals conducted by the American Hospital Association calculated that, in 2017, hospitals only received 87 cents for every dollar they spent caring for Medicare and Medicaid beneficiaries.[18] This problem will only get worse as rural communities age and rural hospitals tend to become even more affected by patients shifting from commercial insurance to Medicare.[19]

***Hospital reimbursement cuts***. Hospitals, which already lose an average of 13 cents on every dollar of government-reimbursed care provided, also have been subject to additional across-the-board federal and state reimbursement cuts, even though the cost of providing services has continued to increase. Cuts include the two percent Medicare payment reduction under Federal Budget Sequestration, a 10% Texas Medicaid outpatient payment reduction in 2011, and a 40% payment reduction for non-urgent use of the emergency room by a Medicaid recipient, among others.[20] The Federal Budget Sequestration was a process introduced by the Budget Control Act to end the 2011 debt-ceiling crisis. It consisted of across-the-board spending cuts that acted as a disincentive to be activated only if Congress did not pass a deficit reduction.[21] Although CMS will implement modest reforms to address the reimbursement gap for rural hospital services, it is too little, too late.[22]

Large disparities remain between urban and rural hospital systems, some of which are likely to worsen, particularly with respect to the population that falls in the coverage gap between Medicaid and the lower limit for Marketplace premium tax credits through the Affordable Care Act ("ACA"). For example, the ACA requires that policymakers reduce Medicaid Disproportionate Share Hospital ("DSH") payments, which are federally mandated payments that state Medicaid programs make to qualifying hospitals that serve a large number of Medicaid and uninsured patients.[23] Congress has delayed the cuts to DSH payments numerous times, and has agreed to keep funding at 2019 levels through May 2020; however, it is expected that the required reductions will be implemented in the near future.[24]

***Services shifting from inpatient to outpatient settings.*** Services increasingly are shifting from an inpatient setting to outpatient settings. For example, outpatient surgeries, laboratory and imaging services were traditionally primarily available in hospitals, but are now offered at stand-

alone facilities or by other providers, such as ambulatory surgery centers and Federally Qualified Health Centers. While this has the benefit of providing greater access to health care and more convenience for patients, ironically, it also reduces the demand for certain services traditionally provided by rural hospitals. Consequently, many rural hospitals must still offer these services, and absorb the associated high fixed costs, yet experience much lower volumes of patients across which those fixed costs may be spread.

***Higher operating costs for rural hospitals***. The operating costs in a rural hospital can be higher on a per-patient basis because of challenging dynamics such as low patient volume, dramatic swings in patient numbers from day to day, recruitment difficulties which can drive up payroll costs, and a general lack of scale economies for high volume purchasing and procurement.[25] In contrast, hospitals in urban areas have comparably lower operating costs due to predictable, high-volume patient flows.[26] Rural hospitals are often plagued by inconsistent patient volume from populations facing more acute health problems.[27] This combination reduces the ability of rural hospitals to negotiate lower prices with suppliers while also requiring rural hospitals to provide expensive health care services. Additionally, rural hospitals often experience significant difficulty in recruiting health care providers to their communities.[28] Rural hospitals have a median wage index that is lower than the median urban hospital wage index.[29] Studies have shown that compensation and base salary is a consideration that has significant influence on a physician's decision to accept a position at a rural hospital.[30] Finally, rural hospitals often struggle with capitalization as it relates to large capital expenses to maintain or replace their facilities and expensive medical equipment.[31]

***Rural populations suffer from more health problems***. The rural hospital crisis is further exacerbated by fundamental health disparities between urban and rural populations. Many studies have shown that rural populations suffer a greater incidence of severe health problems than urban populations.[32] One study notes that the rural health care crisis is exacerbated by the fact that rural populations have a greater rate of diabetes and suffer from a higher exposure to the opioid epidemic.[33]

In Texas, rural populations face numerous health concerns, including adult obesity, lack of health knowledge or education, lack of access to mental health providers, shortage of primary care physicians, and unhealthy behaviors and lifestyles.[34] Moreover, a recent study found that numerous social determinants affect an individual's health status, including access to insurance, income, employment status, and education level achieved.[35] The same study found that:

- 16% of Texas residents do not have health insurance—nearly double the national average of 8.9%;[36]
- rural Texans' per capita income is lower than that of their urban counterparts;
- the unemployment rate in Texas is higher in rural areas than in urban centers; and
- 21.9% of rural Texans do not have a high school diploma, compared with 15.6% of urban populations in Texas.[37]

Additionally, Texas has the largest share of children without health coverage, with more than one in five uninsured children in the United States residing in the state.[38] This highlights the clear need for access to quality health care close to home in rural areas, as well as the fact that rural hospitals often care for patients with co-morbidities that experience multiple chronic conditions and require regular and expensive care. This care may be reimbursed by Medicaid or Medicare, which often does not cover the cost of the care provided, much less generate a positive margin to allow for reinvestment.

***Rural population outmigration***. Nearly 35% of rural counties in the United States are experiencing protracted and significant population loss, according to new research.[39] In Texas, the rural population shrunk from 75.9% of the state's population in 1910 to just 15.3% in 2010.[40] Projections based on historic census data predict that 95% of Texas's population growth will occur in metropolitan areas.[41] The decline in rural populations, however, does not obviate the need for health care services in those areas. As rural populations experience a disproportionately higher incidence of many serious health conditions and significant difficulty in accessing quality medical care, it is essential that people that choose to stay or are unable to move continue to have health care available in and around their local communities.

B. The Effect Of Rural Hospital Closures On Local Economies

As a result of the foregoing conditions, rural populations are particularly vulnerable to hospital closures. These serious financial challenges threaten hospital closures and place enormous economic pressure on local economies. Approximately 64 percent of rural hospitals nationwide are considered highly essential to their community's health and economic well-being.[42] One study, which looked at rural counties experiencing a closure between 1990 and 2000, found that the closure of a single hospital in the community reduced per-capita income and increased the unemployment rate by 1.6 percentage points.[43] Furthermore, when local hospitals close, the people in these communities must drive farther to receive health care services and the overall health of local communities deteriorates.[44]

[redacted] As outlined in detail in the subsequent sections, the proposed transaction would allow Abilene Regional to overcome these challenges to become increasingly effective providers of health care in their respective Midwest Texas communities for years to come.

## V. BENEFITS OF THE TRANSACTION

As described more fully throughout this application, Hendrick's proposed acquisition of Abilene Regional would generate significant benefits for residents across Midwest Texas. By virtue of the transaction, Hendrick will be able to alleviate capacity constraints, enhance patient quality, and expand access for the almost 400,000 people from 24 counties in Midwest Texas who currently rely on Hendrick for care and other regional hospitals. Further, the transaction

would allow Hendrick to achieve greater efficiency and scale, so it could invest in new technology that would improve the patient experience and provide greater access to all community residents.

The hospitals will work better together by focusing on lower-acuity care at Abilene Regional and other community hospitals, while ensuring that higher-acuity care is always available at Hendrick. As a result of the transaction, health care providers at the hospitals will be able to share knowledge and learn from each other to improve quality and the level of services available. As needed, physicians, particularly specialists, could render services at any of the three hospitals, expanding access to a variety of specialties in different locations and leveraging professional expertise to benefit a wider community of patients.

The transaction would coordinate resources and decision-making, resulting in improved efficiency, elimination of waste, and the achievement of cost savings that would be reinvested locally to improve healthcare and maintain jobs in Midwest Texas. Hendrick's commitment to the local community and charity care is evident in its ministry mission. The Gospel-centered mission created at Hendrick over 90 years ago is still the guiding force today as the hospital system continues to seek to earn patients' trust, expand access, and excel in patient engagement. The proposed transaction allows for Abilene and its providers and patients to benefit from Hendrick's commitment to the physical, economic, and social well-being of its community.

## VI. METHODS FOR ACHIEVING THE STATUTORY OBJECTIVES

The Law calls for a determination of whether likely benefits outweigh competitive harms stemming from the transaction and articulates several criteria for the designated state agency (HHSC) to consider. As explained below, the contemplated transaction clearly satisfies these criteria. The Commission should therefore approve the application and issue the COPA.

### A. Quality Metrics

#### 1. Quality Improvement

***Recognition of Hendrick's Quality***. Hendrick has consistently been awarded quality of care accolades. Hendrick Medical Center has been named one of America's Top 250 Hospitals in 2019 and one of America's 100 Best Hospitals for Critical and Stroke Care, according to Healthgrades. Hendrick also received Healthgrades's Excellence and Outstanding Care Awards in Gastrointestinal Care and Women's Health. Hendrick's quality of care has been recognized through numerous awards from highly-regarded national and state organizations, including: the American Heart Association (Stroke Gold Plus Elite); American College of Cardiology (Platinum Performance for Acute Myocardial Infarction); American Hospital Association (Top 23 Most Wired Hospitals in Texas); SafeCare Group (100 SafeCare Hospitals); and Quality Texas Foundation (Performance Award). Additionally, Hendrick was identified in 2019 by Becker's Hospital Review as one of 150 Great Places to Work, and has received the Gallup Great Workplace Award since 2007.

Hendrick has numerous accreditations, certifications, and designations which demand a high level of quality to obtain and maintain. Those include The Joint Commission Accreditation – Hospital and Home Care; The Joint Commission Certifications for Acute Myocardial

Infarction; Primary Stroke and Total Hip/Knee Replacements; Accreditation Commission for Health Care for Durable Medical Equipment; American Academy of Sleep Medicine Accreditation; American Association of Blood Banks (FDA deemed); American Association of Cardiovascular and Pulmonary Rehab Certification – Pulmonary Rehab and Cardiac Rehab; Clinical Laboratory Improvement Amendments (CLIA) Recertification; Breast Institute Accreditation; American College of Radiology Breast Imaging Center of Excellence; American Society of Health-System Pharmacists Residency Program; Intersocietal Commission for the Accreditation of Echo Labs; Texas Department of State Health Services Mammography Accredited Program; Breast Imaging Center of Excellence; Blue Cross Blue Shield Centers of Distinction® for Spine Surgery, Hip and Knee Replacements, and BlueCompare Ribbon for High Quality Healthcare; Infectious Disease Society of America Center of Excellence; Pathways to Excellence® Designation since 2007; Texas Department of Health Primary Stroke Facility in Trauma Service Area D Level II; Texas Department of State Health Services Trauma Level III; Texas Department of State Health Services Neonatal Intensive Care Unit Level III; and Texas Ten Step.

Further, Hendrick is one of only 878 hospitals nationwide to receive Leapfrog's highly-coveted "A" safety grade (the highest possible marker) based on its performance in preventing medical errors, infections, and other harms.[45] Additionally, in November 2019, Hendrick received an upgrade from a CMS 3-Star rating to a 5-Star Hospital rating (to date, this has not been publicly announced).

***Recognition of Abilene Regional's Quality***. Abilene Regional has also received accreditations demonstrating quality healthcare and is accredited by the Joint Commission. Abilene Regional received a "B" grade on the Fall 2019 Leapfrog Safety update.[46] Abilene Regional is an Accredited Chest Pain Center with PCI and its cardiac cath lab is accredited with PCI by the American College of Cardiology.[47] The American Heart Association and American Stroke Association have certified Abilene Regional as a Primary Stroke Center.[48]

***Benefits of the Transaction***. The proposed transaction would allow the parties to maintain the high level of quality at Hendrick while strengthening the quality of care at Abilene Regional by partnering with and learning from Hendrick. Specifically, the transaction would allow Hendrick to disseminate to Abilene Regional the best practices, protocols, and programs that have led to Hendrick's CMS 5-Star rating, "A" Leapfrog rating and multiple quality awards. To that end, Hendrick has implemented many quality improvement and quality assurance programs and activities, and it will further develop and implement the programs across all facilities following the transaction. For example, Hendrick's 2020 quality goals include selected metrics that coincide with publically reported, industry-wide measures, as well as top performer benchmarks. In focusing on quality measure implementation, Hendrick has identified 15 categories with best practice details and objectives. Post-transaction, Hendrick plans to implement these same best practices at Abilene Regional, and incorporate the facilities into its other quality assurance programs. Further, increased coordination of care—clinical integration—between facilities and providers will likely lead to a reduction of medical errors and cost savings, such as those associated with treatments by different physicians who are not coordinating with each other.[49]

2. Facility Improvement

Hendrick prides itself on its longstanding commitment to reinvesting in its operations with the goal of improving patient experience and patient care. Since 2012, Hendrick's capital spending has totaled over $198 million. These capital improvements, from renovating various floors of existing buildings to opening a 38,000 square-foot medical plaza in south Abilene, show Hendrick's commitment to increasing access in its own community. Currently, Hendrick is seeking to improve patient experience at its facilities by embarking on capital improvement projects to develop additional care delivery points and renovate certain portions of the main campus. Recent representative capital improvements include:

- Da Vinci Surgery robot purchase (completed during fiscal year 2019; Hendrick spent approximately $2 million on this project);
- Nursery NICU renovation (completed in December 2017; Hendrick spent approximately $4.3 million on this project);
- Dialysis Center renovation (completed in 2019; Hendrick spent approximately $4.1 million on this project);
- Hendrick Prenatal Clinic (HPC) Fourth Floor renovation (completed in 2019; Hendrick spent approximately $1.6 million on this project); and
- Blood Bank renovation (completed in February 2020; Hendrick spent approximately $1.3 million on this project).

As discussed below, Hendrick is prepared to invest capital in new medical equipment and updates to the physical plant and clinical spaces at the Abilene Regional facilities. Through the transaction, capital needs will be met, benefitting patients, care providers, and employees. Further, Hendrick's commitment to providing capital investment as a means of achieving and maintaining high quality services will ensure that future capital needs at Abilene Regional are met as they arise, enhancing outcomes and the patient experience.

3. Integrated Interoperable Medical Records System

The Abilene community would also benefit from a fully integrated, uniform electronic medical records system deployed across the merged facilities. Currently, Hendrick has a fully integrated electronic records system with AllScripts deployed at all of its sites of care. Abilene Regional uses different records systems depending on the site of care: MedHost for inpatient operations, EDIS for the emergency department, and Athena for outpatient clinics. [redacted]

Having a single records system promoting seamless communication among various providers would lead to more efficient care and ease of use.

Through the transaction, Hendrick and Abilene Regional would have a single, fully integrated and interoperable medical records system so that patient histories and treatment records across the various locations would be readily available to physicians at all system locations in real time. The sharing of information between providers across locations would facilitate better patient care and coordination of treatments and decrease unnecessary duplication of health care services.[50] Additionally, the broader application of a unified electronic medical record system would foster improved population health initiatives by allowing for more robust data analytics. This benefit cannot be realized without the transaction, as implementation of a common IT platform requires sharing of proprietary information and commitment of significant resources by multiple systems, which would be infeasible for independent health systems to pursue.

4. Higher Volumes Are Associated With Better Outcomes

Higher volumes are associated with better outcomes across a wide range of procedures and conditions. This proposition is supported by numerous articles from members of the academic community and governing specialty organizations.[51] Combining the resources of Hendrick and Abilene Regional will allow for the coordination of key service lines that some of the facilities offer separately (such as newborns and deliveries), leading to increased volumes, which will improve quality of those services. Moreover, the transaction will likely allow the development of new services within the community, such as quaternary services, which neither of the entities have the volume to provide separately. Additionally, the combination will allow for the creation of new centers of excellence, which will increase the volumes, and as a result, quality of those services.

The transaction would also allow Hendrick and Abilene Regional to treat a larger combined patient base, thereby enhancing population health efforts. Population Health Management ("PHM"), especially at a local level, could help to alleviate access issues in rural communities. By developing rural accountable care, clinically integrated, and collaborative networks and service delivery platforms, health systems can align rural hospitals and other providers to prepare for and respond to the shift toward value-based health care.[52] PHM can provide a framework for designing, implementing, and measuring the impact of a plan to improve a community's overall health by taking into account a population's varying health needs through engaging with and targeting certain populations.[53] Through PHM initiatives, health systems can gather patient information in an efficient manner to focus on health disparities of smaller sub-populations.[54] In addition, PHM can bolster coordination of care amongst providers and data-driven strategies by collaborating with public health organizations to pool resources and create unified community outreach efforts to enhance proactive health measures.[55]

The population served by Hendrick and Abilene Regional has long had significant health challenges compared to the population in the United States generally. The State of Texas, and particularly the area served by the hospitals, has significantly higher rates of many chronic conditions such as obesity, diabetes, heart disease, and cancer.[56] For comparison purposes, Exhibit C below shows the percentages of physical inactivity, adult obesity, adult smoking, and

number of mentally unhealthy days per month in each of the counties in the service area, the state of Texas, and the United States.[57] The area as a whole, which comprises 24 counties, has higher than average or equal numbers in all categories compared to the state of Texas, and higher averages for physical inactivity and the same average for adult obesity compared to average U.S. percentages. Additionally, Taylor County has higher averages in physical inactivity, adult obesity, and tobacco abuse than both the average Texas percentages and the average U.S. percentages. Taylor County also has a higher average of mentally unhealthy days than the average Texas number (but lower than the average U.S. number). It therefore stands to reason that areas of rural Texas, including Abilene and its surrounding communities, could benefit from increased population health management.

**Exhibit C: Geographic Service Area Health Rankings[58]**

| COUNTY | % Physical Inactive | % Obese (Adult) | Tobacco Abuse (Adult Smoking) | Mentally Unhealthy Days |
|---|---|---|---|---|
| Brown | 29% | 32% | 18% | 3.7 |
| Callahan | 27% | 28% | 16% | 3.8 |
| Coleman | 26% | 28% | 16% | 3.7 |
| Comanche | 26% | 29% | 16% | 3.8 |
| Eastland | 26% | 31% | 16% | 3.8 |
| Fisher | 25% | 28% | 14% | 3.6 |
| Hamilton | 25% | 28% | 14% | 3.6 |
| Haskell | 27% | 28% | 16% | 3.6 |
| Jones | 26% | 30% | 17% | 3.4 |
| Kent | 25% | 28% | 13% | 3.4 |
| Knox | 24% | 29% | 15% | 3.7 |
| Lampasas | 26% | 30% | 15% | 3.6 |
| McCulloch | 27% | 29% | 16% | 3.9 |
| Mills | 26% | 28% | 14% | 3.7 |
| Mitchell | 23% | 31% | 14% | 3.2 |
| Nolan | 29% | 31% | 16% | 3.7 |
| Runnels | 25% | 30% | 15% | 3.6 |
| San Saba | 24% | 30% | 16% | 3.8 |
| Scurry | 26% | 29% | 15% | 3.5 |
| Shackelford | 24% | 30% | 15% | 3.6 |
| Stephens | 26% | 30% | 17% | 3.8 |
| Stonewall | 25% | 28% | 15% | 3.7 |
| ***Taylor*** | ***26%*** | ***32%*** | ***18%*** | ***3.6*** |
| Throckmorton | 25% | 27% | 14% | 3.5 |
| **SERVICE AREA AVERAGE** | **26%** | **29%** | **15%** | **3.6** |

| COUNTY | % Physical Inactive | % Obese (Adult) | Tobacco Abuse (Adult Smoking) | Mentally Unhealthy Days |
|---|---|---|---|---|
| **TEXAS AVERAGE** | **23%** | **29%** | **14%** | **3.4** |
| **US AVERAGE** | **22%** | **29%** | **17%** | **3.8** |

Coordination of population health information and enhancement of population health status are consistent with Hendrick's health goals. In 2019, Hendrick completed a comprehensive Community Health Needs Assessment ("2019 CHNA"). The report involved a year-long study to highlight the more prevalent health needs of residents within Taylor County. Within Taylor County, a higher percentage of people make under $75,000 annually than state and national percentages, and a lower percentage of people make over $75,000 annually than state and national percentages.[59] Those living below poverty level (11.4%) and the uninsured population (14.6%) in Taylor County are similar to state averages.[60]

Hendrick's 2019 CHNA identified improving access to care (including mental health care, substance abuse support, primary care services, and affordable health care services); establishing crisis, emergency care, and early intervention programs for substance abuse; and promoting awareness and prevention of those recovering from substance abuse as the three predominant health needs in the community.

The proposed transaction would expand these goals throughout Hendrick and Abilene Regional's service areas, and would help address the above predominant health needs in the following ways:

- The transaction provides more streamlined provider options for patients by combining the providers at Hendrick and Abilene Regional into one system, and, by using Hendrick's successful recruiting strategies, increases the potential to recruit more physicians to the region.

- Hendrick plans to expand its successful Discharge Navigation Program for emergency department patients to other service lines at Hendrick, and plans to implement this program at Abilene Regional. This program has improved patient satisfaction and experience and helps Hendrick to better meet its patients' needs.

- Hendrick is developing a one-call scheduling system to coordinate patient care referrals to physician and ancillary services. Post-transaction, Hendrick plans to include Abilene Regional in these efforts to make health care across the region more accessible and easier to schedule.

- Hendrick provides Lyft transportation services via Apollo Go (part of Hendrick's Electronic Records System) in Taylor County, and this program could be expanded to Abilene Regional. Post-transaction, Hendrick plans to explore the feasibility of creating a partnership and rural transportation outreach program with regional faith-based organizations.

- Hendrick is developing programs to assess and assist individuals with chronic diseases and to provide financial assistance and education about managing chronic disease and seeking preventive care. Post-transaction, Hendrick plans to implement these programs at Abilene Regional; adding these facilities will increase access by allowing patients to visit numerous locations closer to their homes.

In addition, Hendrick is committed to providing services to meet other health needs of Texans. For example, Texas has one of the highest maternal mortality rates in the U.S., estimated at 14.6 per 100,000 live births.[61] The Texas Department of State Health Services ("DSHS") now designates facilities with levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level of designation and a process for the assignment of levels of care to a hospital. Every Texas licensed hospital that provides maternal care must be designated to receive Medicaid reimbursement by August 31, 2021. In 2019, Hendrick applied for a Level III Maternal Level of Care designation. A Level III maternal designated facility must, among other requirements, provide care for pregnant postpartum patients with conditions ranging from low-risk to significant, complex medical, surgical, and/or obstetrical conditions that present a high risk of maternal morbidity or mortality; and ensure access to a full range of medical and maternal subspecialists, surgical specialists, and behavioral health specialists. Level III facilities must also have physicians with critical care training available at all times (Hendrick currently is the only hospital in Abilene with OB physicians available at all times), facilitate transports, and provide outreach education to lower-designated facilities. Hendrick's survey will be evaluated by DSHS and by the American College of Obstetricians and Gynecologists. Hendrick's commitment to achieving a Level III designation demonstrates its commitment to patient safety and providing quality health care services to its pregnant and postpartum patients.

While Hendrick is working in the community to address and improve these health challenges, the transaction will make it possible to incorporate and utilize Abilene Regional's resources to assist in tackling these challenges. A coordinated and more robust approach will likely have greater reach and overall success across the service area, eliminate unnecessary and duplicative costs, and free up resources of the combined entities to invest in new services and technologies. Separately, as independent systems, the parties are limited from sharing certain information and resources to achieve these initiatives. For example, as discussed above, having an integrated medical records system that can provide comprehensive data analytics on the population served is essential to identifying, addressing, and improving the population health status of the community. The combined entity will attract higher patient volumes across the system that will foster more successful PHM initiatives.

B. Price Metrics

Robust competition between the combined entity and other hospitals will continue in the region and beyond following Hendrick's acquisition of Abilene Regional. In this case, there are separate supervision provisions in place to ensure that consumers will not be harmed by the transaction with respect to prices for health care services.

1. The Parties Must Justify Price Increases And Receive Approval Of The Designated Agency

The Law prevents the parties from increasing inpatient and outpatient prices without justifying such increases to, and receiving approval from, the designated agency. As a preliminary matter, the vast majority of patients at Hendrick and Abilene Regional are insured by government payors which set the reimbursement rates for those patients without negotiation. [redacted] Nonetheless, there are multiple mechanisms in place restricting Hendrick's ability to raise prices post-closing. First, for any change for inpatient and outpatient service rates, the parties must seek approval from the HHSC at least 90 days before the change would take effect. Second, for any change in reimbursement rates under an agreement with a third party payor, the parties must submit a proposal to the designated agency for a change in rates at least 60 days before the execution of a third party payor's reimbursement agreement. The parties must describe the justification for the changed rate, if the proposed rates are above a benchmarking amount chosen by the HHSC. Third, for any agreement with insurers that provides for health care services under Medicaid or Medicare, the parties must provide similar justification to the HHSC for the proposed rates, and describe whether the proposed rates exceed the previous rates. For any submission related to a change in rates, the parties must also provide information concerning costs, patient volume, payor mix, acuity, and other information requested by the HHSC. After reviewing the changes, the HHSC can reject or approve the proposed rates.

Given the effect of the relevant legislation and the resulting active supervision by the HHSC, the parties are prevented from lessening the ability of health care payors to negotiate payment and service arrangements with the hospitals proposed to be merged under the agreement.[62]

2. The Transaction May Also Facilitate New Payment Models That Incentivize Better Quality And Lower Cost

The transaction may also facilitate new payment models. Because the statute and active supervision by the HHSC restricts the parties from gaining revenue by simply raising prices, it is likely the parties will be forced to move away from fee-for-service models to value-based models. In a fee-for-service model, providers are paid on a per patient, per visit basis—regardless of clinical outcome. Today, reimbursement models are moving towards value-based reimbursement systems, which consider clinical outcomes in provider reimbursement and generally provide differential payments based on measures of clinical quality and cost.[63] For example, a valued-based model can reimburse providers based on their ability to deliver timely and appropriate care. By rewarding providers for their ability to deliver care more timely and appropriate care, value-based models, in turn, reward greater provision of quality care, improved access, and lower cost than traditional payment models. Value-based models support the goals of health reform: improving patient experience, improving population health, and reducing per capita costs of health care.[64]

The statute's restrictions on raising prices and subsequent supervision over pricing incentivizes the combined organization to consider innovative payment models. The combined entity can establish payment models that are increasingly favored by commercial payors, such as shared savings programs, bundled payments and capitation. These programs are all ways of participating in value-based care, and are linked to improvements in health care cost savings, increased quality, and better health care spending.[65] Relatedly, the transaction will allow the combined entity to facilitate these new payment models with payors. Value-based models are all linked to better care coordination, lower administrative costs with savings used for service line expansions, and increased points of access focusing on convenience to patients and accessibility.[66]

C. Preservation And Access To Care

The same headwinds facing rural hospitals generally, discussed above, are present in Taylor County and surrounding counties. Over the last few years, the population of Taylor County has grown at a fraction of the rate of the State of Texas as a whole. For example, in 2018, Taylor County had a population density of 150 people per square mile, which did not even place it in the top 25 counties in Texas by population density.[67] It is also notable that a high proportion of Abilene Regional's patients are insured by Medicare or Medicaid.

Alignments with existing hospitals are one way to ease the significant financial challenges that rural hospitals face. Hendrick's resources can support implementation of robust outreach initiatives, educational goals, and other access to care promotions for the rural Texas community by Abilene Regional. Together, the hospitals can treat a rural population that is older and poorer, while maintaining and promoting services in the community.

Rural hospitals in the U.S. are facing challenging dynamics that lead to higher operating costs: low patient volume, dramatic daily and seasonal swings in patient numbers, and recruitment difficulties which drive up provider costs. Through the transaction, the combined entity could mitigate the severe risks facing rural hospitals that would otherwise threaten access to care generally across the area.

1. Clinical Optimization Aids Access To Care

[redacted]

[redacted]

[redacted]

It is only through the proposed transaction that the parties have the incentive and ability to coordinate care in a way that improves efficiency and increases the quality of care provided to patients in the Midwest Texas region.

2. Capacity Improvements Ensure Greater Access To Care

The proposed transaction would alleviate Hendrick's capacity problems and help better meet the community's needs. Regularly operating at a capacity of 74% or above, Hendrick is unable to fully meet the local community demand for its services. The lack of excess inpatient capacity is due to two issues. First, because Hendrick is the only provider of certain services in Abilene and has more capabilities to care for critically ill patients than other area providers, Hendrick does its best not to turn away patients. Hendrick has the only Level III trauma center and Level III NICU in the Abilene area, and has a greater ability to care for patients with complex cases than other hospitals. Second, from time to time, Hendrick must close units and renovate and update them. These renovations have sometimes caused beds to become unavailable; for example, in 2014, Hendrick spent almost $10 million renovating different floors of the Jones Building. Today, due to renovations, Hendrick has only 442 available beds out of the 540 beds for which Hendrick is licensed. As explained above, not all of those hospital beds are "interchangeable."

Hendrick estimates that it needs 100 additional beds for telemetry, medical surgical, and ICU services to meet community demand. But Hendrick has no additional space for more inpatient beds on its campus: there is no room to grow in its existing configuration without ending certain services or undergoing a major construction project. Initially, Hendrick sought to construct new facilities; but constructing new facilities—whether they are bed towers, women's/children's centers, or clinics—is not in the best interest of the community's immediate health care needs as it can be a lengthy, costly process. With other clinical facilities such as Abilene Regional having available capacity, the most direct path to alleviating capacity constraints is by leveraging Hendrick's higher acuity service offerings and physician coverage capabilities to Abilene Regional, which will allow more fulsome utilization of those facilities. And, Hendrick can use a common IT platform with its counterparts to deliver better patient outcomes, patient safety and coordination of care. With a common IT platform and more space, Hendrick believes it can eliminate patient diversions while providing the most appropriate care in the most appropriate clinical setting. This transaction will make room for additional patients by increasing capacity while saving construction costs.

3. Preservation of Hospital Services Ensures Access to Care

***Ministry and not-for-profit status***. Hendrick's mission to deliver high quality health care is consistent with its history and strong community ties. For example:

- Hendrick is affiliated with the Baptist General Convention of Texas (the "BGCT"). Through its continued visits with BGCT affinity groups, Hendrick has

focused on evaluating how the organization's mission is carried out through its Mission and Ministry Committee.

- Hendrick has established The Hope Fund, a financial assistance mission to ensure that no one in the Abilene community goes without a mammogram due to financial limitations. Its mission is to provide hope and financial assistance to overcome breast cancer through early detection. The Hope Fund provides mammography services free of charge for women who are unable to afford the procedure.

- Hendrick partners with faith-based organizations across its service area to educate patients about health care resources available in the community, and explore opportunities for faith-based and non-profit collaborations. These efforts could be bolstered through the inclusion of Abilene Regional's additional efforts, post-transaction.

Hendrick plans to continue its commitment to service and the local area by expanding these resources, supplies, and high-quality care to underserved patient populations that currently choose Abilene Regional as their primary site of care.

***Improving Existing Access Points***. Hendrick has recognized consistently the need to provide greater outreach for rural communities and improve access points to health care. Its current regional relationships and outreach services exemplify this: Hendrick has relationships with 21 hospitals and over 250 health care providers outside of Abilene. Its educational programs for community members and rural outreach show the commitment to rural care and medical education that Hendrick believes is crucial for its community. For example, Hendrick offers the following rural outreach programs:

- Sexual Assault Nurse Examiner (SANE) program / forensic nursing services.

- Allscripts EMR Hub & Spoke offering, which does away with an inefficient "plug and play" model by arranging service delivery assets into a network consisting of an anchor establishment (hub). The hub offers a full array of services, complemented by secondary establishments (spokes) which offer limited service arrays and routes patients needing more intensive services to the hub for treatment (in short, getting patients in rural areas the right care at the right time).

- Health Information Exchange (HIE) Network offering, which allows medical providers, pharmacists, and patients to appropriately access and securely share a patient's vital medical information electronically. Hendrick is part of Healthcare Access San Antonio (HASA), a HIE whose members collaborate on clinical patient information sharing across Texas with the goal of reducing admissions and improving patient outcomes.

- Emergency operations center for the region, serving as a coordination hub and control facility for decision-makers and response team personnel.

- Diabetes education center, offering self-management education as an integral component of diabetes care.

- Neonatal transport services, including a coordinator who develops protocols and training programs for neonatal transport.

- Over 60 outreach clinics, including cardiology, endocrinology, otolaryngology (ENT), gastroenterology, hematology/oncology, interventional radiology, and more.

After the transaction, Hendrick plans to expand access to the communities it serves, for example by adding urgent care centers in Taylor County.

4. Improved Recruitment Opportunities Will Also Expand Access To Care

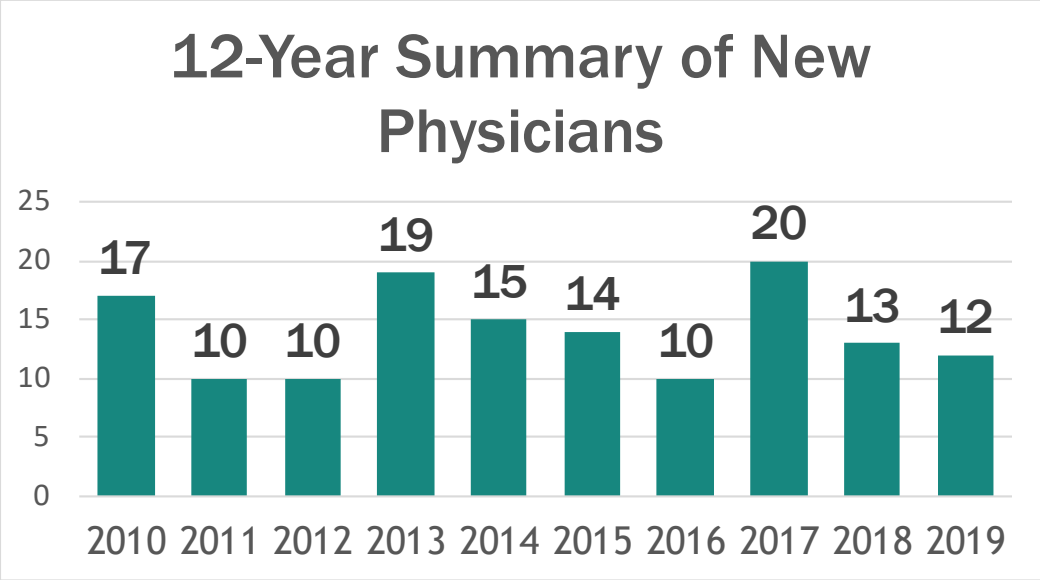
As previously discussed, Midwest Texas faces a shortage of physicians and other skilled caregivers. Through the transaction, Hendrick will be better positioned to recruit and retain the very best talent.

Historically, Hendrick has been successful in recruiting and retaining medical care providers. A dedicated, in-house physician recruitment department with two recruiters oversees physician recruitment efforts. The recruitment department uses multiple platforms to attract new physicians to the community. These platforms include success through word-of-mouth referrals, online platforms (such as Doximity, PracticeLink, Practice Match, and CareerMD), Texas career fairs, residency and fellowship program visits, and contingency firms (to date, Hendrick has more than 160 agreements in place with these firms).

Once the recruitment department makes outreach to physicians, Hendrick curates its recruiting visits. First, each recruiting visit is structured to include scheduled meals with current community physicians and their family members. Second, recruits are treated to a community tour, including schools and housing, one-on-one meetings with Hendrick's executive leadership, and other social activities. All expenses are paid.

Hendrick's recruitment efforts speak for themselves. In the past three years, Hendrick has hired 45 new physicians and hosted almost 100 recruiting events. These recruits are not only primary care physicians, but physicians with highly specialized expertise. (For example, Hendrick successfully recruited two additional cardiovascular surgeons in the last year).

**Exhibit D: Hendrick's 12-Year Summary of New Physicians**




Not only does Hendrick succeed in recruiting a large number of physicians, Hendrick is successful in retaining those physicians and other medical providers to stay in the community. Within the previous four fiscal years, Hendrick has only experienced a total of 24 physician departures—and almost half of the departures were due to retirements. Only four were due to relocations from the system. Hendrick's turnover rate among nurses is 11.43%, compared to the Texas turnover rate of 24%.

Hendrick's successful retention of employees is due to a few factors. First, Hendrick historically has had high employment satisfaction ratings. A 2019 Medical Staff Survey revealed that Hendrick earned a mean rating of 4.5 out of 5 regarding the level of physician satisfaction with the quality of care across all shifts and departments (a rating of "5" represents "extremely satisfied"). Second, Hendrick entices its nurses to stay by offering an AACN Transition to Practice Nurse residency program. The Nurse Residency Program focuses on new entry-level nurses as they transition into practice. The evidenced-based curriculum incorporates three key areas: leadership; patient outcomes; and professional development, empowering nurses by supporting their professional development with a data-driven solution. [redacted]

Many U.S. hospitals the size of Abilene Regional find it challenging to recruit and retain physicians, particularly in specialized fields due to call coverage support. Recruitment of nurses and other skilled employees can be difficult given fewer job opportunities and limited housing for the partners and family of nursing staff, and lower salaries offered when compared to facilities in larger cities. Coverage from contract nursing staffing agencies is one way to fill the labor gap but this is expensive.

The transaction could alleviate some of these challenges and lead to a more effective recruitment and outreach strategy. Post-transaction, Hendrick plans to continue its strong

recruitment efforts to hire excellent candidates that fit its culture. Hendrick is planning to recruit cardiovascular surgeons, cardiologists, nurses, family practice practitioners, and other skilled clinical caregivers. To support its recruitment efforts, Hendrick plans to facilitate visits at medical residencies and develop outreach programs at targeted businesses and groups around the state. Through this transaction, Hendrick will have greater scale and appeal to recruit new physicians for all facilities.

D. Efficiencies

The transaction will produce a variety of important efficiencies, further benefiting consumers. Hendrick has identified ways to eliminate significant ongoing duplication of costs through coordination. Funding population health, access to care, enhanced health services, and other commitments would be difficult without the efficiencies and savings created by the merger. While Hendrick expects to see cost savings and efficiencies across the combined network, the most significant cost savings—and the focus of this analysis—come from the ability to avoid additional capital expenditures, optimize care, and eliminate redundancies. Hendrick estimates that, as a result of the transaction, the combined system may achieve at least

[redacted]

1. Clinical Optimization

[redacted]

2. Selling, General, And Administrative (SG&A)

Hendrick estimates that savings from the transaction include both labor and non-labor savings. With regard to potential labor savings, Hendrick is committed to the parties' existing workforces, and the combined system intends to offer all current employees comparable positions. However, with time, including through attrition, the combined entity will reduce duplication, temporary staffing needs, and other premium labor costs. In many cases, employees

can be moved into new or expanded roles to optimize existing expertise and competencies within the integrated delivery system.

[redacted]

A significant portion of these savings would be reinvested through financial commitments in the development and continuation of programs outlined above, including services for indigent care, behavioral health services, community health improvement initiatives, and academic or educational outreach. Hendrick strongly believes that the net effect of the transaction on the health care workforce in the region will be positive.

3. More Efficient Use Of Capital

The transaction will allow for more efficient capital spending and utilization of clinical and administrative resources across the organizations. As such, the parties can avoid significant planned capital projects, [redacted]

[redacted]

Hendrick has identified a near-term need for 100 additional inpatient beds in order to alleviate current capacity constraints resulting from increasing patient volumes and the potential closure of the outdated Anderson Building (including 80 semi-private inpatient beds), which was constructed in 1962 and requires significant renovations in order to remain operational. Prior to planning to acquire Abilene Regional, Hendrick looked to deactivate the Anderson Building and expand the Jones Building (an inpatient bed tower) by six additional floors. This capital improvement update would result in the addition of 138 beds at Hendrick (or a net bed impact of 58 beds when accounting for the closure of the Anderson Building) and will cost up to [redacted] In addition, an estimated [redacted] expansion of the warehouse and kitchen facilities at Hendrick would also be required in order to support the expanded inpatient space at the Jones Building. Instead, Hendrick can use Abilene Regional's available space—including its available 231 licensed beds and open fifth floor that is underutilized—to avoid this six-floor expansion.

In addition, Hendrick has plans to spend over [redacted] to construct an 85,000 square feet expansion of its Heart Center. The project would add areas to the existing Heart Center; rework site planning, parking, and landscaping, and move existing cardiology consultants to make room for testing areas and cath labs. Instead, Hendrick can forgo the [redacted] by using Abilene Regional's existing space and cath labs.

[redacted]

The renovation costs associated with repurposing the Abilene Regional facilities and equipment for the above purposes was estimated at [redacted]—significantly less than what Hendrick would have had to spend for the construction of a six floor expansion to the Jones Building (and related expansion to the warehouse and kitchen facilities), the expansion to the Heart Center, and the development of a geriatric clinic. After netting renovation costs from the

potential capital avoidance cost savings, Hendrick is expected to save at least [redacted] in additional capital expenditures by using Abilene Regional's existing structures. The transaction will allow the parties to more efficiently utilize clinical and administrative space across the two organizations and therefore avoid significant planned capital projects.

The efficiencies and cost savings created by this transaction will fund population health, access to care, enhanced health services, and other community-oriented commitments. By aligning Hendrick and Abilene Regional's efforts in key service lines and other areas, the combined system will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services.

4. One-Time Costs

[redacted]

The efficiencies and cost savings created by this transaction will fund population health, access to care, enhanced health services, and other commitments. By aligning Hendrick and Abilene Regional's efforts, the combined system will drive cost savings, resulting in more efficient and higher quality services.

5. Hendrick Could Use All Of The Foregoing Savings To Benefit The Local Community

The savings that would result from the coordination of services, clinical optimization, and capital avoidance can be redeployed towards improving patient care coordination. Better coordinated care results in fewer medical complications, which results in lower overall costs of care. Additionally, these savings could be used to expand service offerings and offer greater points of access. All of this would increase the quality and breadth of care beyond what is available in the region today.

E. Competition Among Providers

The Law provides that the HHSC's evaluation of the proposed transaction shall include consideration of whether the parties will continue their competitive position, and any reduction in competition among physicians, allied health professionals, other health care providers, or other persons providing goods or services to, or in competition with, hospitals.

The transaction will not result in a meaningful reduction in competition among physicians, allied health professionals, other health providers, or any other persons providing

goods or services in competition with the hospitals. Hendrick would have no power to exercise any market power stemming from any reduction in competition, because a condition of the issuance of the COPA would be thorough, ongoing, and sustained supervision by State regulators. Among other stringent controls on the conduct of the hospitals following the transaction, the statute provides that no "change in rates for hospital services operating under a COPA may "take effect without prior approval of the designated [supervisory] agency." Health & Safety Code § 314A.102(a). Thus, the Law prevents any exercise of anticompetitive pricing powers; Hendrick would have no ability to raise prices even *within* the competitive range (let alone above it) without obtaining agency approval. The Law provides for a variety of other supervisory powers by the state that would ensure that the transaction would entail no competitive harms at all.

Even putting aside this dispositive fact, the transaction would still not create any competitive harms. While the Commission need not reach this question in order to approve the application, it is significant that Hendrick and Abilene Regional are not close substitutes. As shown above, even though there are similarities between the general inpatient and outpatient services offered by the two hospitals, there are significant differences in the depth and breadth of the services that each party provides. Compared to Abilene Regional, Hendrick attracts patients from a broader area, provides more specialized services, and cares for more severely ill patients.

Competition is valued because of the benefits that it can provide consumers. The "principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively."[68] If the agreement is consummated, the transaction's net effect will be to promote, not lessen, the traditional benefits of competition in the parties' geographic areas. Indeed, the transaction promotes competition between such persons or entities and the hospitals, as well as creates opportunities for savings. As the parties continue to recruit physicians, nurses, and other health providers, Hendrick and Abilene Regional will increase the providers in the community, which naturally will spur competition among other inpatient and outpatient facilities in the region, while generating substantial efficiencies.

1. Competition With Other Inpatient Facilities And Freestanding Emergency Departments

Hendrick and Abilene Regional face competition from a number of hospitals and health systems in their primary and secondary service areas. Post-transaction, the parties will continue to compete with large and significant health systems throughout the region, most of which are gaining strength. The robust competition for inpatient hospital services will continue from at least 20 other hospitals, listed in Appendix C, all located in surrounding counties, following consummation of the transaction.

Likewise, the parties also face competition from freestanding emergency departments, which are separately licensed facilities that provide emergency services and often provide related ancillary services such as laboratory and pharmacy services. Notably, Hendrick and Abilene Regional both face current competition from freestanding emergency departments, including two in Abilene, as listed in Appendix D.

In addition, patients from Abilene travel to facilities outside of Taylor County for secondary and tertiary services. In 2018, Hendrick estimated that over 47% of patients in its 24-county service area, comprised of almost 400,000 people, traveled to non-Hendrick and non-Abilene Regional facilities for inpatient services. Hendrick considers these facilities as competitors for higher-end services. In 2018, hospitals such as University Medical Center and others received patients from Abilene Regional seeking high-acuity care. Through better coordination of care and elimination of unnecessary and wasteful spending, the combined entity will free up capital to expand high-acuity service offerings, keeping more care local.

2. Texas Does Not Require Hospitals To Apply For Certificates Of Need

Many states limit health care providers' ability to expand services by requiring them to seek government approval for new entry and expansion of health care providers. State certificate-of-need ("CON") laws typically establish requirements for state approval before a new health care provider can enter a market or an existing provider can make certain capital improvements. For example, if a hospital wants to build a wing or add additional beds, it must seek approval from the state. The state will determine whether there is sufficient public "need" for the capital improvement and either grant or deny the provider's application. CON laws reduce competition and innovation. CON laws are simply output restrictions that displace competition with regulation and prevent new providers from expanding or entering.[69] The weakest providers—the ones that are inefficient and most susceptible to competition—are likely to benefit from the shelter of CON laws. By eliminating competition, CON laws drive up cost, lower quality, and limit the availability of needed services.[70]

Texas is not a CON state. Unlike the 36 states and District of Columbia that have CON regulations, providers in Texas are not shielded by CON laws that force health care providers to seek government approval before expanding facilities, offering new services, or purchasing new equipment. Hendrick and Abilene Regional will continue to face the threat of significant competition from other potential providers that can challenge the hospitals simply by arriving at their doorstep.

3. The Combined Entity Will Continue to Face Competition With Other Health Systems In The Region And Beyond

Many health systems in Texas are currently undergoing significant facility and service expansions. For example:

- With 1,034 licensed beds, the University Health System in San Antonio is the largest hospital in San Antonio and is a nationally recognized teaching hospital and network of outpatient health care centers, providing over 15 specialties and subspecialties. The University Health System in the planning stages of a $500 million expansion project expected to open in late 2022. The expansion includes a new 12-story, 300-bed hospital for women, babies, and children, a new 900-space parking structure, and additional shell space for future growth.[71]

- Newly opened in 2017, Houston Methodist – The Woodlands has 146 licensed and staffed beds, and provides numerous inpatient services, including cancer care,

cardiology, neurology, neurosurgery, orthopedics, sports medicine, surgery and women's health. In July 2019, Houston Methodist – The Woodlands announced a $240 million expansion that includes a new patient tower for an additional 100 beds and 10 new operating rooms as well as expansions of the endoscopy center, heart center, diagnostic imaging department, and emergency center.[72]

- The 878-bed, $1.3 billion Parkland Health & Hospital System opened four years ago in downtown Dallas. Parkland Health & Hospital System offers, among other high-end inpatient services, a Level I Trauma Center, the second largest civilian burn center in the U.S., and a Level III Neonatal Intensive Care Unit. In early 2019, Parkland Health & Hospital System in Dallas began a $154 million expansion project that includes a six-story medical building that will house the hospital's new comprehensive breast care center.[73]

- Texas Health Harris Methodist Hospital Alliance, located in Fort Worth, has 101 licensed beds and provides medical services such as women's health, emergency care, and heart and vascular services. In 2018, the hospital announced plans for a $74.2 million expansion that will consist of a 65,000 square foot addition to the facility that will house units for critical care, medical-surgical, women and infants' services, along with a new surgical suite and support services wing.[74]

- Announced in late 2018, Texas Health Resources in Mansfield, Texas started construction on a new four-story hospital in Mansfield. The $150 million project will add a 192,400 square foot hospital with 95 beds initially and provide a full range of medical services, including intensive care units, general surgery, women's surgery, orthopedics, a pharmacy, interventional cardiology, and an 80,000 square foot medical office building.[75] Due to open in late 2020, the construction plans also include space for the hospital to expand in the future.

4. The Combined Entity Will Continue To Face Competition From Outpatient Facilities And Post-Acute Care Facilities

Services can be categorized into inpatient and outpatient depending on where the procedure is performed and the length of stay; outpatient services usually consist of low-acuity procedures that do not require an overnight stay at a hospital. Outpatient care includes ambulatory surgery centers, primary care clinics, retail clinics, community health clinics, urgent care centers, specialized outpatient clinics, imaging service facilities and emergency departments.[76] As patient volumes are increasingly shifting from inpatient to outpatient settings, the availability of these services will only increase.[77] Overall, the shift to outpatient services has been caused by clinical innovation, patient preferences, and financial incentives.[78]

There are a number of competing independent outpatient facilities, independent nursing homes, assisted living facilities, skilled nursing facilities, and hospice care facilities located in Taylor and surrounding counties that compete for patients with the parties. Hendrick and Abilene Regional together account for 53 out of 103, or 51.45%, of the outpatient and post-acute care facilities in Taylor County, including one out of 12, or 8.33%, of the skilled nursing facilities. Here, for present purposes, only competing outpatient and post-acute care facilities in

Taylor County, and not adjacent counties, were considered, due to the generally localized nature of such services. Outpatient services including urgent care, imaging, and ambulatory surgery centers have many independent alternatives. Studies have shown that residents of small towns in Texas prefer to drive 40 to 50 minutes to receive inpatient services at a hospital in a larger city, where they believe they will receive better care than in their own community.[79] But for outpatient and post-acute services, studies have shown that most parties prefer to remain within their local area to receive health care services for a minor medical condition.[80]

Appendix D provides a listing of other health care facilities within Hendrick and Abilene Regional's immediate community.

5. The Combined Entity Will Continue To Face Competition From Independent Physicians

Over 63,000 physicians provide services in Texas—almost 350 of whom practice in Taylor County.[81] Hendrick and Abilene Regional continue to value a robust and successful independent physician community. The combined entity intends to collaborate where possible with the independent physician community in procompetitive arrangements to build an array of service offerings that will be accessible throughout the region. Studies have shown that patients usually make a choice concerning specialists based on physician referrals.[82] The independent physicians in the community will maintain the ability to refer patients to any health care facility. As has always been the case, none will be required to refer to Hendrick or Abilene Regional. The more efficient use of the combined and integrated facilities, however, will offer those physicians a more stable platform with enhanced capability, allowing them to deliver timely and more effective care to their patients.

6. The Transaction Will Enhance Competition

Strategic collaborations—including mergers—are recommended for organizations that "effectively advocate for, naturally represent, and have trusted relationships with rural constituents to maximize opportunities for efficient use of resources towards systemic and sustained improvements."[83] This is because overall, collaboration between providers of essential health services may meet the needs of rural populations better than if they did not work together.[84] Strategic combinations involving rural hospitals can combine resources to improve access to health care services for rural populations, improve health care quality, create cost saving efficiencies, and provide for opportunities to enhance health knowledge programs.[85] Hospital strategic collaborations can be crucial to address the unique set of system-related problems in rural areas.[86] In particular, a health care-related strategic combination can create more specialty positions and increase brand recognition that can improve rural recruiting.

In short, under this statutory framework, the proposed combination will not give rise to market power or otherwise harm competition. The combined entity will be actively supervised by Texas officials. Active supervision includes submission to and review by the HHSC and the Attorney General of an annual report, as well as the rate review process described here. This supervision will ensure that the combined entity will act in furtherance of the public policies that underlie the Texas legislation's statutory provisions. Moreover, the combined entity will continue to face competition from several independent general acute care hospitals, outpatient

facilities, post-acute care facilities and physicians in the geographic service area. Further, post-transaction, the combined entity will continue to operate fully and competitively if the application is granted. For example, most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, and others. Hendrick and Abilene Regional are required to ensure patient choice when selecting these services and will continue to adhere to these policies as a merged organization.

## VII. CONCLUSION

In evaluating this transaction, state officials need not be concerned that better quality and access will lead to supracompetitive prices. The parties will operate under a tightly regulated regime that will prohibit them from increasing reimbursement rates above competitive levels. Most importantly, no alternative arrangements would achieve the same level of benefits that this transaction provides. These local hospital systems will become fully integrated, offering convenient, affordable care to residents of Abilene and the surrounding communities. The transaction promotes system-wide coordination of community health initiatives. The hospitals can jointly recruit highly-trained providers, while expanding services locally, thereby reducing the need for patient outmigration. The benefits listed above as well as many other benefits from the transaction could be lost to the community if the application is not approved.

## Appendix A: Hendrick Locations in Taylor County

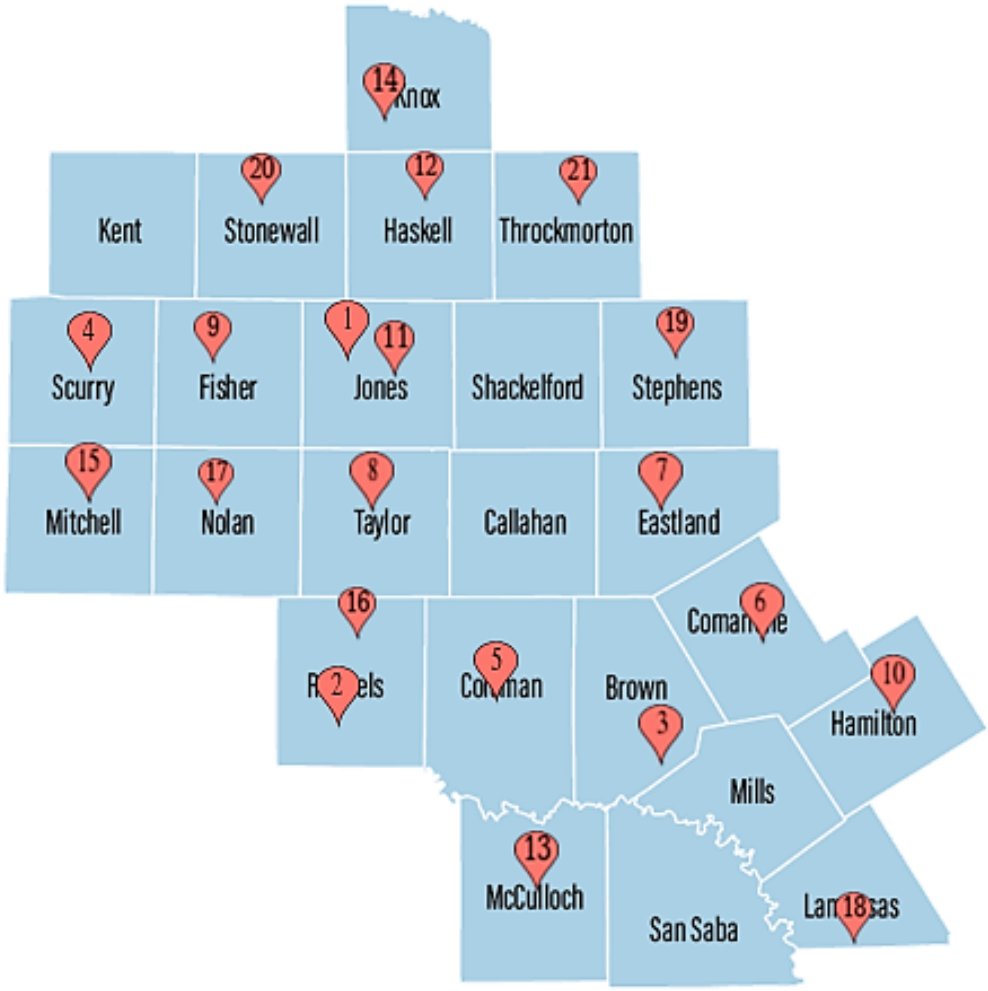
| | |
|---|---|
|  Taylor County | • Hendrick Asthma Education Program<br>  ○ 1857 Pine Street, Abilene, TX 79601<br>• Hendrick Cancer Center<br>  ○ 2000 Pine Street, Abilene, TX 79601<br>• Hendrick Cardiovascular Care<br>  ○ 1900 Pine Street, Abilene, TX 79601<br>• Hendrick Center for Rehabilitation<br>  ○ 1934 Hickory Street, Abilene, TX 79601<br>• Hendrick Diabetes Center<br>  ○ 1742 Hickory Street, Abilene, TX 79601<br>• Hendrick Hospice Care<br>  ○ 1651 Pine Street, Abilene, TX 79601<br>• Hendrick Medical Center<br>  ○ 1900 Pine Street, Abilene, TX 79601<br>• Hendrick Medical Plaza & Hendrick Emergency Care Center South<br>  ○ 5302 Buffalo Gap Road, Abilene, TX 79606<br>• Hickory Center & Vera West Women's Center<br>  ○ 1850 Hickory Street, Abilene, TX 79601 |

## Appendix B: Abilene Regional Locations in Taylor County

| | |
|---|---|
|  Taylor County | • Abilene Regional Medical Center<br>  ○ 6250 US-83, Abilene, TX 79606<br>• Abilene Orthopaedic Institute<br>  ○ 1888 Antilley Road, Suite 200, Abilene, TX 79606<br>• Abilene Physicians Group Administration<br>  ○ 6250 Regional Plaza, Suite 1010, Abilene, TX 79606<br>• Abilene Physicians Group Primary Care<br>  ○ 6250 Regional Plaza, Suite 1060, Abilene, TX 79606<br>• Abilene Regional Ambulatory Surgery Center<br>  ○ 6399 Directors Parkway, Suite 100, Abilene, TX 79606<br>• Abilene Regional Medical Center Cardiopulmonary Services<br>  ○ 1680 Antilley Road, Suite 220, Abilene, TX 79606<br>• Abilene Regional Medical Center Office Space<br>  ○ 6150 Regional Plaza, Abilene, TX 79606<br>• Abilene Regional Medical Center Office Space<br>  ○ 52 Windmill Circle, Abilene, TX 79606<br>• Abilene Regional Medical Center Quality Department<br>  ○ 1680 Antilley Road, Suite 265, Abilene, TX 79606<br>• Abilene Regional Medical Outpatient Imaging Center<br>  ○ 1665 Antilley Road, Suite 205, Abilene, TX 79606<br>• Abilene Regional Medical Diagnostic Imaging Center<br>  ○ 1665 Antilley Road, Suite 300, Abilene, TX 79606<br>• Cardiology, Regional Plaza<br>  ○ 6200 Regional Plaza, Suite 1675, Abilene, TX 79606<br>• Cardiology, Antilley Road<br>  ○ 1680 Antilley Road, Suite 125, Abilene, TX 79606<br>• Cardiology, Antilley Road<br>  ○ 1680 Antilley Road, Suite 270, Abilene, TX 79606<br>• Care Transition Clinic<br>  ○ 6250 Regional Plaza, Abilene, TX 79606<br>• Family Medicine, Regional Plaza<br>  ○ 6300 Regional Plaza, Suite 875, Abilene, TX 79606<br>• Family Medicine, Regional Plaza<br>  ○ 6300 Regional Plaza, Suite 260, Abilene, TX 79606<br>• Family Medicine, Windmill Circle<br>  ○ 35 Windmill Circle, Abilene, TX 79606<br>• Gastroenterology, Antilley Road<br>  ○ 1680 Antilley Road, Suite 120, Abilene, TX 79606<br>• Gastroenterology, Regional Plaza<br>  ○ 6300 Regional Plaza, Suite 820, Abilene, TX 79606 |

| | |
|---|---|
| | • Internal Medicine, Antilley Road<br>  o 1680 Antilley Road, Suite 200, Abilene, TX 79606<br>• Internal Medicine, Regional Plaza<br>  o 1680 Antilley Road, Suite 1000, Abilene, TX 79606<br>• Internal Medicine, Regional Plaza<br>  o 1680 Antilley Road, Suite 1060, Abilene, TX 79606<br>• OB/GYN, Antilley Road<br>  o 1680 Antilley Road, Suite 115, Abilene, TX 79606<br>• OB/GYN, Antilley Road<br>  o 1680 Antilley Road, Suite 310, Abilene, TX 79606<br>• South Abilene Surgical Associates<br>  o 1680 Antilley Road, Suite 110, Abilene, TX 79606 |

## Appendix C: Inpatient Facilities Within Hendrick's Primary and Secondary Service Area




| # | Hospital Name | Address | County |
|---|---|---|---|
| 1 | Anson General Hospital | 101 Ave. J,<br>Anson, TX 79501 | Jones |
| 2 | Ballinger Memorial Hospital District | 608 Ave. B,<br>Ballinger, TX<br>76821 | Runnels |
| 3 | Brownwood Regional Medical Center | 1501 Burnett Rd<br>Brownwood, TX<br>76801 | Brown |

| | | | |
|---|---|---|---|
| 4 | Cogdell Memorial Hospital | 1700 Cogdell Blvd., Snyder, TX 79549 | Scurry |
| 5 | Coleman County Medical Center | 310 S Pecos St., Coleman, TX 76834 | Coleman |
| 6 | Comanche County Medical Center | 10201 TX-16, Comanche, TX 76442 | Comanche |
| 7 | Eastland Memorial Hospital | 304 S Daugherty Ave., Eastland, TX 76448 | Eastland |
| 8 | Encompass Health Rehabilitation Hospital of Abilene | 6401 Directors Pkwy., Abilene, TX 79606 | Taylor |
| 9 | Fisher County Hospital District | 774 TX-70, Rotan, TX 79546 | Fisher |
| 10 | Hamilton General Hospital | 400 N Brown St., Hamilton, TX 76531 | Hamilton |
| 11 | Hamlin Memorial Hospital | 632 NW 2nd St., Hamlin, TX 79520 | Jones |
| 12 | Haskell Memorial Hospital | 1 Ave., Haskell, TX 79521 | Haskell |
| 13 | Heart of Texas Healthcare System | P.O. Box 1150, Brady, TX 76825 | McCulloch |
| 14 | Knox County Hospital District | 701 S E 5th St., Knox City, TX 79529 | Knox |
| 15 | Mitchell County Hospital | 997 I-20, Colorado City, TX 79512 | Mitchell |
| 16 | North Runnels Hospital | 7821 TX-153, Winters, TX 79567 | Runnels |
| 17 | Rolling Plains Memorial Hospital | 200 E Arizona Ave., Sweetwater, TX 7955 | Nolan |
| 18 | Rollins Brook Community Hospital | 608 N Key Ave., Lampasas, TX 76550 | Lampasas |
| 19 | Stephens Memorial Hospital | 200 S Geneva St., Breckenridge, TX 76424 | Stephens |
| 20 | Stonewall Memorial Hospital | 821 N Broadway St., Aspermont, TX 79502 | Stonewall |

| | | | |
|---|---|---|---|
| 21 | Throckmorton County Memorial Hospital | 802 N Miner Ave., Throckmorton, TX 76483 | Throckmorton |

## Appendix D: Other Health Care Facilities in Taylor County

| | Name | Address | County |
|---|---|---|---|
| **Ambulatory Surgical Centers**[87] | | | |
| | Abilene Cataract & Refractive Surgery Center | 2120 Antilley Rd., Abilene, TX 79606 | Taylor |
| | Abilene Center for Orthopedic and Multispecialty Surgery, LLC | 6449 Central Park Blvd., Abilene, TX 79606 | Taylor |
| | Abilene Endoscopy Center | 1249 Ambler Ave., Suite 100, Abilene, TX 79601 | Taylor |
| | Abilene Spine & Joint Surgery Center PA | 1888 Antilley Rd., Abilene, TX 79606 | Taylor |
| | Abilene Surgery Center LLC | 5601 Health Center Dr., Abilene, TX 79606 | Taylor |
| | Abilene White Rock Surgery Center, LLC | 2401 N Treadaway Blvd., Abilene, TX 79604 | Taylor |
| | ELM Place Ambulatory Surgical Center | 2217 S Danville Dr., Abilene, TX 79605 | Taylor |
| | Facial Plastic & Cosmetic Surgical Center | 6300 Regional Plaza Suite 475, Abilene, TX 79606 | Taylor |
| | Texas Midwest Surgical Center | 751 N 18th St., Abilene, TX 79601 | Taylor |
| **Assisted Living Facilities**[88] | | | |
| | Ambers House | 3264 Varner Ln., Abilene, TX 79601 | Taylor |
| | Andress House | 3257 Varner Ln., Abilene TX 79601 | Taylor |
| | Chisholm Place | 1450 E N 10th Street, Abilene, TX 79601 | Taylor |
| | Choices Residential Assisted Living | 1610 Orange Street, Abilene, TX 79601 | Taylor |
| | Covenant Place of Abilene | 3234 Buffalo Gap Road, Abilene, TX 79606 | Taylor |
| | Fulwiler House | 1551 Fulwiler Rd., Abilene, TX 79601 | Taylor |
| | Highland Assisted Living LLC | 2310 S Seventh, Abilene, TX 79605 | Taylor |
| | Kenneth Hart | 1742 Sayles Blvd., Abilene, TX 79605 | Taylor |
| | Lyndale Abilene Memory Care | 6568 Park Central Blvd., Abilene, TX 79606 | Taylor |

| | | | |
|---|---|---|---|
| | Lyndale at Abilene | 6565 Central Park Blvd., Abilene, TX 79606 | Taylor |
| | The Wood Group | 858 Formosa St., Abilene, TX 79602 | Taylor |
| | Wesley Court Assisted Living Center | 22617 Antilley Rd., Abilene, TX 79606 | Taylor |
| | Wisteria Place Assisted Living Center | 3202 S Willis St., Abilene, TX 79605 | Taylor |
| **Freestanding Emergency Medical Care Facilities**[89] | | | |
| | Express ER | 4157 Buffalo Gap Rd., Abilene, TX 79605 | Taylor |
| | My Emergency Room 24/7 | 4438 S Clack St. Suite 100, Abilene, TX 79606 | Taylor |
| **Hospice Agencies**[90] | | | |
| | Kindred Hospice | 1665 Antilley Rd., Suite 300, Abilene, TX 79606 | Taylor |
| | Hospice of the Big Country | 4601 Hartford, Abilene, TX 79605 | Taylor |
| | Interim Hospice of West Texas | 4400 Buffalo Gap Rd., Suite 2500, Abilene, TX 79606 | Taylor |
| | Kinder Hearts Hospice | 842 N Mockingbird Lane, Abilene, TX 79603 | Taylor |
| **Select Other Health Care Facilities** | | | |
| | Abilene Community Health Center | 1749 Pine St., Abilene, TX 79601 | Taylor |
| | Abilene Diagnostic Clinic | 1665 Co Rd. 314, Suite 200, Abilene, TX 79606 | Taylor |
| | Abilene Taylor County Public Health District | 850 N 6th St., Abilene, TX 79601 | Taylor |
| | Affordacare Urgent Care Clinic | 4006 Ridgemont Dr., Abilene, TX 79606 | Taylor |
| | Affordacare Urgent Care Clinic | 3101 S 27th, Abilene, TX 79605 | Taylor |
| | Allergy and Asthma Clinic of Abilene | 2100 Antilley Rd., Abilene, TX 79606 | Taylor |
| | Cook Children's Health Care System | 410 Lone Star Dr., Abilene, TX 79602 | Taylor |
| | Medical Diagnosing Imaging of Abilene | 4349 S. Treadaway Blvd., Abilene, TX 79602 | Taylor |
| | Texas Oncology – Abilene | 1957 Antilley Rd., Abilene, TX 79606 | Taylor |

| | | | |
|---|---|---|---|
| | Tim Martin M.D. (Independent Physician Office) | 2110 N Willis St., Suite B, Abilene, TX 79603 | Taylor |
| | Walk-In Care Clinic | 1665 Antilley Rd. Suite 120, Abilene, TX 79606 | Taylor |
| **Skilled Nursing Facilities**[91] | | | |
| | The Oaks at Radford Hills | 725 Medical Drive, Abilene, TX 79601 | Taylor |
| | Brightpointe at Lytle Lake | 1201 Clarks Dr., Abilene, TX 79602 | Taylor |
| | Coronado Nursing Center | 1751 N 15th St., Abilene, TX 79603 | Taylor |
| | Merkel Nursing Center | 1704 N 1st, Merkel, TX 79536 | Taylor |
| | Mesa Springs Healthcare Center | 7171 Buffalo Gap Rd., Abilene, TX 79606 | Taylor |
| | Northern Oaks Living & Rehabilitation Center | 2722 Old Anson Rd., Abilene, TX 79603 | Taylor |
| | Silver Spring | 1690 N Treadway Blvd., Abilene, TX 79601 | Taylor |
| | Wesley Court Health Center | 2617 Antilley Rd., Abilene, TX 79606 | Taylor |
| | Willow Springs Health & Rehabilitation Center | 4934 S 7th St., Abilene, TX 79605 | Taylor |
| | Windcrest Health & Rehabilitation | 6050 Hospital Rd., Abilene, TX 79606 | Taylor |
| | Wisteria Place | 3202 S Willis St., Abilene, TX 79605 | Taylor |

**Appendix E:**

**Copy of the Agreement**

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[1] Hendrick Health System, About Us, http://www.hendrickhealth.org/main/mission.aspx.

[2] CHS is a publicly traded holding company. CHSPSC, LLC, an affiliated entity, provides certain consulting services to Abilene Regional.

[3] H.B. 3301, Bill Analysis, https://capitol.texas.gov/tlodocs/86R/analysis/pdf/HB03301H.pdf#navpanes=0.

[4] "Merger" is defined by the Law as "an agreement among two or more hospitals for the consolidation by merger or other acquisition or transfer of assets by which ownership or control over substantially all of the stock, assets, or activities of one or more previously licensed and operating hospitals is placed under the control of another licensed hospital or hospitals or another entity that controls the hospitals."

[5] The Governor signed the bill in June 2019 and the Law became effective on September 1, 2019. *See* H.B. 3301, 86th Leg. (2019), https://legiscan.com/TX/bill/HB3301/2019.

[6] iVantage Health Analytics, "Rural Relevance – Vulnerability to Value – A Hospital Strength INDEX Study," (Feb. 2016) at 5, https://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf.

[7] Determining whether a location is "rural" or "urban" is difficult to delineate; multiple maps published by the U.S. Department of Agriculture show most counties surrounding Tom Green County are "rural," and large swaths of Tom Green County are "rural." Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study" (Mar. 2017), at 66, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf; *see* U.S. Dep't of Agriculture, "Texas," https://www.ers.usda.gov/webdocs/DataFiles/53180/25598_TX.pdf?v=0.

[8] Ellison, A., "State-by-State Breakdown of 113 Rural Hospital Closures," Becker's Hospital CFO Report (Aug. 26, 2019), https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-113-rural-hospital-closures-082619.html.

[9] Chang, J., "Losing a Lifeline – What Happened When Milam County's Two Hospitals Closed," GATE HOUSE NEWS (Jul. 26, 2019), https://gatehousenews.com/texas-rural-hospital-closings/.

[10] Texas Organization of Rural & Community Hospitals (TORCH), "Twenty-Five Things to Know About Texas Rural Hospitals," (Revised Sept. 2019), https://files.constantcontact.com/1355b334201/562b2e28-4dfe-41be-9e18-256b232ae044.pdf.

[11] United States and Texas Populations. https://www.tsl.texas.gov/ref/abouttx/census.html.

[12] *Id*.

[13] Ramshaw, E., "No Country for Health Care, Part 1: Far From Care," THE TEXAS TRIBUNE (Jan. 4, 2010), https://www.texastribune.org/2010/01/04/health-care-sparse-in-rural-texas/.

[14] Texas Organization of Rural & Community Hospitals (TORCH), "Twenty-Five Things to Know About Texas Rural Hospitals," (revised Sept. 2019), https://files.constantcontact.com/1355b334201/562b2e28-4dfe-41be-9e18-256b232ae044.pdf.

[15] Texas Counties by Population, Cubit, https://www.texasdemographics.com/counties_by_population; County Information, Texas Association of Counties, https://imis.county.org/iMIS/CountyInformationProgram/TexasMapCIP.aspx.

[16] *See* List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties, Health Resources & Services Administration, https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/resources/forhpeligibleareas.pdf; Texas Counties by Population, Cubit, https://www.texas-demographics.com/counties_by_population.

[17] Beutke, K. et al., "A Path Forward for Rural Healthcare," KAUFMANHALL (Apr. 26, 2019), https://www.kaufmanhall.com/sites/default/files/documents/2019-04/a-path-forward-for-rural-healthcare.pdf.

[18] American Hospital Association "Underpayment by Medicare and Medicaid Fact Sheet," (Jan. 2019), https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf.

[19] Beutke, K. et al., "A Path Forward for Rural Healthcare," KAUFMANHALL (Apr. 26, 2019), at 1, https://www.kaufmanhall.com/sites/default/files/documents/2019-04/a-path-forward-for-rural-healthcare.pdf.

[20] Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study," (Mar. 2017), https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[21] Pub. L 112-25, S. 365, 125 Stat. 240 (enacted Aug. 2, 2011).

[22] CMS implemented a wage index boost in its final rule on inpatient prospective hospital payments for fiscal year 2020. This rule will benefit rural hospitals by addressing the wide gap in Medicaid payments for hospital services, however this measure may be inadequate to address the significant longstanding and ongoing financial challenges faced by many rural hospitals. Luthi, S., "CMS Finalizes Rural Wage Index Boost," Modern Healthcare (Aug. 2, 2019), https://www.modernhealthcare.com/payment/cms-finalizes-rural-wage-index-boost.

[23] LaPointe, J., "Hospitals Seek Another Delay for $4B Medicaid DSH Payment Cut," Revcycle Intelligence, xtelligent Healthcare Media (Feb. 22, 2019), https://revcycleintelligence.com/news/hospitals-seek-another-delay-for-4b-medicaid-dsh-payment-cut.

[24] La Pointe, Jacqueline "Funding Legislation Delays $4B in Medicaid DSH Payment Cuts," (Dec. 20, 2020), https://revcycleintelligence.com/news/funding-legislation-delays-4b-in-medicaid-dsh-payment-cuts; *see also* Ollove, M., "Rural and Safety Net Hospitals Prepare for Cut in Federal Support," Stateline, PEW (Oct. 31, 2019), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/10/31/rural-and-safety-net-hospitals-prepare-for-cut-in-federal-support.

[25] *See* Ellison, A., "Rural vs. Urban: A Comparison of Hospitals Costs and Charges," (Feb. 9, 2016), https://www.beckershospitalreview.com/finance/rural-vs-urban-a-comparison-of-hospital-costs-and-charges.html; *see also* Williams, D., "Rural Health Care Costs Are They Higher and Why Might They Differ from Urban Health Care Costs?" NORTH CAROLINA MEDICAL JOURNAL (Feb. 2018), http://www.ncmedicaljournal.com/content/79/1/51.full#xref-ref-3-1; LaPointe, J. "41% of Rural Hospitals Operating with Negative Margins," Rev Cycle Intelligence (Jul. 6, 2017), https://revcycleintelligence.com/news/41-of-rural-hospitals-operating-with-negative-margins.

[26] Ellison, A., "Rural vs. Urban: A Comparison of Hospitals Costs and Charges," (Feb. 9, 2016), https://www.beckershospitalreview.com/finance/rural-vs-urban-a-comparison-of-hospital-costs-and-charges.html.

[27] *Id*., *see also* LaPointe, J. "41% of Rural Hospitals Operating with Negative Margins," Rev Cycle Intelligence (Jul. 6, 2017), https://revcycleintelligence.com/news/41-of-rural-hospitals-operating-with-negative-margins.

[28] Rural Health Information Hub, "Recruitment and Retention for Rural Health Facilities," https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention; *see also* Rosenberg, J., "Understanding the Health Challenges Facing Rural Communities," AMERICAN JOURNAL OF MANAGED CARE (Feb. 5, 2019), https://www.ajmc.com/conferences/academyhealth-2019/understanding-the-health-challenges-facing-rural-communities.

[29] Thompson, Kristie W., "Rural/Urban and Regional Variation in the 2019 CMS Hospital Wage Index," NC Rural Health Research Program (May 2019), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2019/04/Wage-Index-Geo-Variation.pdf

[30] Stajduhar, T., "Rural Physician Recruitment – Results from the 2019 Rural Physician and Administration Study," Jackson Physician Search (Jul. 2019), at 3, https://www.jacksonphysiciansearch.com/white-paper-rural-recruitment/.

[31] American Hospital Association, "Rural Report – Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care," (2019), at 7, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

[32] *See, e.g.*, Rural and Urban Health, Health Policy Institute, Georgetown University, https://hpi.georgetown.edu/rural/.

[33] Topchik, M., "Rural Relevance 2017: Assessing the State of Rural Healthcare in America," The Chartis Group (2017), https://www.chartis.com/forum/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf.

[34] *See e.g.*, Shannon, "Community Health Needs Assessment 2019" at 7, https://www.shannonhealth.com/media/2314/final_shannon-chna-2019.pdf.

[35] Rural & Community Health Institute, Texas A&M University, "What's Next? Practical Suggestions for Rural Communities Facing a Hospital Closure," at 6, https://www.episcopalhealth.org/files/2414/9788/5907/Whats_Next_Final_6.12.pdf.

[36] *See id.*; *see also* Fernandez, S., "Texas has the most people without health insurance in the nation – again," THE TEXAS TRIBUNE (Sept. 10, 2019), https://www.texastribune.org/2019/09/10/texas-has-most-people-without-health-insurance-nation-again/.

[37] *Id.*; *see also* Rural & Community Health Institute, Texas A&M University, "What's Next? Practical Suggestions for Rural Communities Facing a Hospital Closure" https://www.episcopalhealth.org/files/2414/9788/5907/Whats_Next_Final_6.12.pdf (citing the rural Health Information Hub, *Texas: State Guide*, https://www.ruralhealthinfo.org/states/texas).

[38] Alker, J. & Roygardner, L., "The Number of Uninsured Children is on the Rise," Center for Children and Families, Georgetown University Health Policy Institute (Oct. 2019), at 7, https://ccf.georgetown.edu/wp-content/uploads/2019/10/Uninsured-Kids-Report.pdf.

[39] Johnson, K. & Lichter, D., "Rural Depopulation in a Rapidly Urbanizing America," Carsey School of Public Policy, University of New Hampshire (Feb. 2019), https://carsey.unh.edu/publication/rural-depopulation.

[40] Urban Texas, Texas Demographic Center (Aug. 2017), at 1, https://demographics.texas.gov/Resources/publications/2017/2017_08_21_UrbanTexas.pdf.

[41] *Id.* at 2.

[42] Navigant, "Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents," (Feb. 2019), at 2, https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf.

[43] Holmes, G., et al., "The Effect of Rural Hospital Closures on Community Economic Health," 41 HEALTH SERV. RES. 2, 467-85 (Apr. 2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/pdf/hesr041-0467.pdf.

[44] *Id.* at 481.

[45] Hendrick Health System, Leapfrog Hospital Safety Grade, https://www.hospitalsafetygrade.org/h/hendrick-health-system.

[46] Abilene Regional Medical Center, Leapfrog Hospital Safety Guide, https://www.hospitalsafetygrade.org/h/abilene-regional-medical-center.

[47] "ARMC Recognized for Excellence with ACC Cardiac Cath Lab Accreditation with PCI," https://www.abileneregional.com/news-room/armc-recognized-for-excellence-with-acc-cardiac-ca-14232.

[48] *See* https://www.abileneregional.com/hospital-awards-accreditation.

[49] Bresnick, J., "Care Coordination Technique Reduces Medical Errors by 30%," Health IT Analytics (Nov. 7, 2014), https://healthitanalytics.com/news/care-coordination-technique-reduces-medical-errors-30 (reporting that better care coordination among residents reduced patient safety issues and medical errors by nearly one-third); Starmer, A., et al., "Integrating Research, Quality Improvement, and Medical Education for Better Handoffs and Safer Care: Disseminating, Adapting, and Implementing the I-PASS Program," Joint Commission Journal on Quality and Patient Safety (2017), https://www.jointcommissionjournal.com/article/S1553-7250(17)30176-9/fulltext (finding that the implementation of a coordinated care program resulted in substantial reductions in medical errors).

[50] *See, e.g.,* O'Brien, J., "Advocate Unifies EHR Platform Ahead of Merger with Aurora," HealthLeaders (Feb. 1, 2018), https://www.healthleadersmedia.com/innovation/advocate-unifies-ehr-platform-ahead-merger-aurora (Advocate Health Care touting its plan to transition to a single EHR by Epic ahead of Advocate's planned merger with Aurora Health Care, which is in line with the health system's efforts to improve consumer experience, improve coordination and operational efficiency, and provide "the highest quality and safest care" for patients).

[51] *See e.g.*, Institute of Medicine, "Interpreting the Volume-Outcome Relationship in the Context of Health Care Quality: Workshop Summary" (2000), at 4-5, https://www.nap.edu/catalog/10005/interpreting-the-volume-outcome-relationship-in-the-context-of-health-care-quality.

[52] Population Health Management: Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study" (Mar. 2017), at 52, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[53] Swarthout, M. & Bishop, M., "Population Health Management: Review of Concepts and Definitions," American Society of Health-System Pharmacists, Inc. (Sept. 2017), at 1408 https://academic.oup.com/ajhp/article/74/18/1405/5102626; "Implementing a Successful Population Health Management Program," Philips White Paper, at 5, https://www.usa.philips.com/c-dam/b2bhc/us/Specialties/community-hospitals/Population-Health-White-Paper-Philips-Format.pdf.

[54] *Id*. at 7.

[55] "Population & Public Health" The Office of the National Coordinator for Health Information Technology, Section 10.2 – Use Population Health Management Tools, https://www.healthit.gov/playbook/population-public-health/#section-10-2.

[56] National Center for Health Statistics "Stats of the State of Texas" Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/pressroom/states/texas/texas.htm.

[57] Robert Wood Johnson Foundation & the University of Wisconsin Population Health Institute, "County Health Rankins & Roadmaps," https://www.countyhealthrankings.org/.

[58] Robert Wood Johnson Foundation & the University of Wisconsin Population Health Institute, "County Health Rankins & Roadmaps," https://www.countyhealthrankings.org/.

[59] 2019 Community Health Needs Assessment, Hendrick Health System, at 12, http://www.hendrickhealth.org/Uploads/Public/Documents/AboutUs/CHNA%20Booklet%202019-Electronic.pdf.

[60] *Id*. at 13.

[61] Johansen, K., "The fight to end Texas' high maternal mortality rate," PBS.COM (May 25, 2019), https://www.pbs.org/newshour/show/the-fight-to-end-texas-high-maternal-mortality-rate.

[62] Research suggests that health insurers already exercise market power. One study assessed whether health insurers charge higher premiums to employers that earn higher profits. *See e.g.*, Bates, L. et al., "Do Health Insurers Possess Market Power?" American Society of Health Economists (June 1, 2010), at 5, https://ssrn.com/abstract=1879652. The study found evidence of this behavior and concluded that health insurers possess and exercise market power in an increasing number of geographic markets. *Id*. at 21.

[63] National Institute of Diabetes and Digestive and Kidney Diseases, "Changing Landscape: From Fee-for-Service to Value-Based Reimbursement," https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/why-transform/changing-landscape-fee-service-value-based-reimbursement.

[64] "The Defining Features of Current Value-Based Care Models," (Sept. 23, 2019), https://healthpayerintelligence.com/news/the-defining-features-of-current-value-based-care-models ("The success of value-based care models depends on care coordination, risk management, quality measurement, and adaptability"); Kent, J., "Value-Based Hospitals More Likely to Adopt Population Health Tools," Health Analytics (Jan. 17, 2019), ("Hospitals participating in value-based care models are investing more than their peers in . . . .solutions to help support population health management, data analytics, and care coordination capabilities"); Deloitte, "Value of

patient experience," May 15, 2017, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-value-patient-experience-050517.pdf ("With the market shift towards value-based and patient-centered models of care, improving patient experience is an increasingly common focus for hospitals").

[65] *See, e.g.,* Beaton, T., "Why Bundled Payments Are a Popular Option for Healthcare Payers," (Dec. 11, 2017), https://healthpayerintelligence.com/news/why-bundled-payments-are-a-popular-option-for-healthcare-payers ("Bundled payments have linked to improvements in healthcare cost savings for both payer and provider organizations").

[66] *See, e.g.,* Beaton, T., "Payers See Cost, Quality Gains with Value-Based Payment Models," Healthpayer Intelligence.com (Aug. 28, 2018), https://healthpayerintelligence.com/news/payers-see-cost-quality-gains-with-value-based-payment-models ("Value-based models are delivering on their promises to reduce costs and improve quality of care").

[67] "Top 25 Texas Counties Ranked by Population Density," Town Charts, https://www.towncharts.com/Texas/Top-25-Counties-in-Texas-ranked-by-Population-Density.html.

[68] Philip E. Areeda & Herbert Hovenkamp, Antitrust Law: An Analysis of Antitrust Principles and Their Application: Vol. 1, 4 (2nd ed. 2000).

[69] Ohlhausen, M., "Certificate of Need Laws: A Prescription for Higher Costs," 30 Antitrust 1 (Fall 2015), at 51, https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf.

[70] Fottler, M. & Frimpong, J., "The Effects of Certificate of Need Regulation on Hospital Costs," 36 J. HEALTH CARE FIN. 1, 11 (2010) (finding that CON laws "may actually increase costs"); Stratmann, T. & Wille, D., "Certificate of Need Laws and Hospital Quality," Mercatus Center (Sept. 2016) ("CON regulations lead to lower-quality care for some measures of quality").

[71] "Growing to Meet the Needs of South Texas," University Health System, https://www.universityhealthsystem.com/about-us/expansion.

[72] "$240 Expansion Planned for Houston Methodist Woodlands," HOUSTON CHRONICLE (Jun. 3, 2019), https://www.houstonchronicle.com/news/health/article/240M-expansion-planned-for-Houston-Methodist-13924999.php.

[73] "Parkland Hospital to Add Six-Story, $154 Million Clinics and Office Building," THE DAILY MORNING NEWS (Jan. 14, 2019), https://www.dallasnews.com/business/real-estate/2019/01/14/parkland-hospital-to-add-six-story-154-million-clinics-and-office-building/.

[74] "74 Million Alliance Forth Worth Hospital Expansion Joins Texas Health's Growth Spurt," DALLAS NEWS (Dec. 21, 2018), https://www.dallasnews.com/business/real-estate/2018/12/21/74-million-alliance-fort-worth-hospital-expansion-joins-texas-health-s-growth-spurt/.

[75] 'This New Mansfield Hospital Will Add 280 Jobs, Offer Unique Approach to Patient Care," FORT WORTH STAR-TELEGRAM (Oct. 10, 2018), https://www.star-telegram.com/news/local/community/mansfield-news-mirror/article219701595.html.

[76] Deloitte Insights "Growth in Outpatient Care – The Role of Quality and Value Incentives," Center for Health Solutions, Deloitte (2018), at 5, https://www.modernhealthcare.com/assets/pdf/CH116784829.PDF.

[77] Advisory Board, "The Outpatient Shift Continues: Outpatient Revenue Now 95% of Inpatient Revenue, New Report Reveals," (Jan. 8, 2019), https://www.advisory.com/daily-briefing/2019/01/08/hospital-revenue (reporting hospitals' net outpatient revenue in 2017 was $472 billion, while net inpatient revenue totaled almost $498 billion).

[78] See *id*. at 2.

[79] Chang, J., "Losing a Lifeline – What Happened When Milam County's Two Hospitals Closed," GATE HOUSE NEWS (Jul. 26, 2019), https://gatehousenews.com/texas-rural-hospital-closings/.

[80] 2011 Survey of Health Care – Consumers in the United States – Key Findings, Strategic Implications, Deloitte Center for Health Solutions, Deloitte, at 17, http://www.statecoverage.org/files/Deloitte_US_CHS_2011ConsumerSurveyinUS_062111.pdf.

[81] Tameez, H., "Why Does it Take so Long to Get a Doctor's Appointment?" FORT WORTH STAR-TELEGRAM (Mar. 1, 2019), https://www.star-telegram.com/news/local/fort-worth/article225525290.html.

[82] *See e.g.*, Ross, J. & Detsky, A., "Choice? Making Health Care Decisions in the United States and Canada," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (Oct. 28, 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835156/.

[83] Strategic Collaborations: Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study," (March 2017), at 52, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[84] *See supra* note 3, at 53.

[85] U.S. Department of Health and Human Services, Health Resources and Services Administration, "A Guide for Rural Health Care Collaboration," (2019), at 2, https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/resources/hrsa-rural-collaboration-guide.pdf.

[86] *Id*.

[87] Directory of Ambulatory Surgical Centers, Health and Human Services Commission, Texas Health and Human Services, https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/asc/directory-ambulatory-surgical-centers.pdf.

[88] Long-term Care Provider Search, Texas Health and Human Services, https://apps.hhs.texas.gov/LTCSearch/.

[89] Freestanding Emergency Medical Care Facilities, Profession Roster Report, Texas Department of State Health Services, https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/freestanding-emergency/femc-directory.pdf.

[90] Long-term Care Provider Search, Texas Health and Human Services, https://apps.hhs.texas.gov/LTCSearch/.

[91] *Id.*